

Albany Farm Care (Hampshire) Limited

Holt Farm Care Limited

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 30 January 2018 and was unannounced.

At the last inspection in February 2017, the service was rated 'Requires Improvement'. At this inspection we found that the service to be 'Good'. At our previous inspection, we had asked the provider to take action to make improvements and provide people with opportunities to engage in activities. At this inspection we checked to see if the provider had made the necessary improvements. We found that relevant improvements had been made.

The service provides care for up to six people with learning disabilities or mental health needs. At the time of the inspection there were five people living at the service. Holt Farm Care Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service was registered prior to the publication of Registering the Right Support. All but one person have lived there for a number of years. The service reflects values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in post at the time of our inspection. 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.

The registered manager had identified potential risks to each person and had put plans in place to support staff to reduce these risks.

Staff understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise any concerns they may have.

Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these from happening again. Staff were trained in the safe management of people's behaviours that cause harm to people themselves or others.

People were supported to take their medicines safely by suitably trained staff. Medication administration records (MAR) confirmed people had received their medicines as prescribed. The service was clean and well maintained.

The service followed safe recruitment practices that helped ensure only staff who were of good character and suitable to work in care were employed.

New staff completed an induction designed to ensure they understood their new role before being permitted to work unsupervised. Staff received regular support and one-to-one sessions or supervision to discuss areas of development. They completed a wide range of training and felt it supported them in their job role.

People's needs and choices were assessed and support was delivered in line with current guidance. People's independence was promoted.

Staff sought consent from people before providing care or support. The ability of people to make decisions was assessed in line with legal requirements to ensure their liberty was not restricted unlawfully.

Staff supported people to access the healthcare services they needed to maintain their health and referred people to specialist support when necessary.

People were cared for with kindness and compassion. Care plans provided comprehensive information about how people wished to receive care and support. This helped ensure people received personalised care in a way that met their individual needs.

A complaints procedure was in place. Information was available for people and their relatives to make a complaint and relatives were confident the registered manager would respond appropriately if they raised any concerns.

Effective leadership was visible across the service and the registered manager, the regional manager and staff had a good understanding of their roles and responsibilities. The provider had a range of audits in place to assess, monitor and drive improvement. However, the service did not always adhere to the provider's policy on reviewing risk assessments.

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.

Risks to people were identified and managed safely.

Staff understood how to respond if they suspected people were being abused to keep them safe.

Staffing levels were sufficient to meet people's needs. Recruiting practices were safe.

People received their medicines safely.

Is the service effective?

Good 

The service was effective.

People's needs and choices were fully assessed.

People were cared for by staff who knew their needs well.

Staff were supported with training, supervision and appraisals to meet people's needs.

Staff were aware of their responsibilities in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to access health professionals and treatments.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs.

Is the service caring?

Good 

The service was caring.

People felt staff treated them with kindness and compassion.

People were treated with dignity and respect and were encouraged to remain as independent as possible.

People were involved in planning their care and supported to maintain important relationships.

Is the service responsive?

Good ●

The service was responsive.

People were encouraged to take part in a wide range of activities.

People received care that was personalised to them. People's records gave staff the information they needed about people's history, preferences, interests, goals and aspirations.

People and their relatives were provided with information on how to raise concerns and complaints.

Is the service well-led?

Good ●

The service was well-led.

There was a transparent and open culture within the service.

People, their families and staff spoke highly of the manager who was approachable and supportive, and felt the home was well run.

Staff felt supported through regular meetings and feedback.

Quality assurance systems and audits helped monitor and improve the service.

Holt Farm Care Limited

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 unannounced inspection took place on 30 January 2018 and was carried out by one inspector.

Before the inspection, the provider had 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 the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries. The provider is legally obliged to send us this information within required timescales. The PIR was used as a prompt to follow up specific areas at the inspection and to support our findings.

We spoke with two people who used the service and one relative of a person. We also spoke with the registered manager, the director of care, the team leader and two care staff members. We looked at a range of records which included care records for four people, medicines records and recruitment records for four members of staff. We looked at other records in relation to the management of the service, such as health and safety documentation, minutes of staff meetings and quality assurance records. Following the inspection, we also received feedback from two external healthcare professionals.

Is the service safe?

Our findings

People we spoke with told us or indicated to us that they felt safe. One person said, "Yes, I feel safe here". Another person expressed their satisfaction with the service by saying, "I feel safe and happy". One person's relative told us, "I feel all the residents are safe, well cared for and fulfilled according to their abilities and needs".

Risks to people had been assessed in areas such as accessing the community, using steps or stairs, receiving personal care or suffering an epileptic seizure. Staff we spoke with were aware of these risks and could describe the support needed to be provided to manage them safely. People were supported by staff who knew them well and knew how to mitigate risks to people's health and well-being.

Sometimes people could become distressed and behave in a way that put themselves or other people at risk. Risks associated with behaviour that challenged others were assessed. Behaviour support plans were individualised and set out certain patterns of behaviour that might be hazardous. The plans also instructed staff what action should be taken to help prevent the behaviour. They also included guidance for staff on how to support people in the least restrictive way possible if the behaviour did occur. For example, staff were instructed not to leave one person without any interaction as this would lead to the person displaying behaviour that may challenge.

People benefited from being cared for by staff who understood the whistleblowing procedure and would use it if needed. Staff told us that if they had concerns, they would speak immediately to their manager. If they felt they were not being listened to, they would escalate their concerns further to senior management in the organisation. Staff knew what to do if safeguarding concerns were raised and appropriate systems were in place to protect people from abuse and help keep them safe. It was clear from the interviews we had with care staff that they understood what abuse was, and what they needed to do if they suspected abuse had taken place. A member of staff told us, "I would let the management know about the incident, I would report this to them and to the safeguarding team".

People were protected from discrimination as all members of staff received training in equality and diversity. A member of staff told us, "We protect people against discrimination because of their age, race, disability or sexual orientation. If I see any type of the discrimination, I will report this to the management".

Robust recruitment processes were in use which meant staff were checked for suitability before being employed in the service. Staff records included an application form and a record of their interview, two written references and a check with the Disclosure and Barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff told us and records confirmed this process was followed before they started working at the service.

There were enough staff deployed to meet the needs of people and keep them safe. During the inspection we saw staff were not rushed and responded promptly and compassionately to people requesting support.

Staffing levels were determined by the number of people using the service whose needs were also taken into account. People and staff told us the number of staff was sufficient to look after people's routine needs and support people individually to access community activities. A member of staff told us, "I feel there are enough of us to support service users".

Details of incidents were recorded together with the action taken at the time of the occurrence, and notes of those who had been notified, such as relatives or healthcare professionals. The records also included information about what action had been taken to avoid any future incidents. All incidents were monitored to look for possible triggers and patterns of people's behaviour. The registered manager gave examples where information had been used to inform people's behaviour profiles to help prevent further risk. For example, the service had significantly reduced the number of behavioural incidents by providing a person with a written activity schedule.

Staff told us they understood their responsibilities to raise concerns, to record safety incidents, concerns and near-misses, and to report them internally and externally where appropriate. They told us that any lesson learned from this would be immediately communicated to staff. A member of staff told us, "If there was an accident or incident that resulted due to our negligence, like for example, we used equipment that was broken, this would be communicated to us with the message to check the equipment before we start using it".

People received their prescribed medicines as and when they needed them. Medicines were stored appropriately and securely. Health action plans included specific information to direct care staff as to how people should be supported with their medicines. There were up-to-date policies and procedures in place to support staff and to ensure medicines were managed in accordance with current regulations and guidance. Training records showed staff were suitably trained and assessed as competent to administer medicines.

For people who were prescribed medicines 'as and when required', there was clear guidance in place for when such medicines should be administered, for example, when a person needed pain relief. This meant staff had access to information to assist them in their decision making about when such medicines could be used.

The home was maintained safely. Health and safety checks were routinely carried out at the premises and systems were in place to report any issues of concern. The provider had reviewed the environment in order to make improvements and an up-to-date action plan was in place. During our inspection, we saw the kitchen was being refurbished and there were plans in place to improve the driveway.

Robust contingency plans and systems were in place to ensure the service ran smoothly in the event of untoward emergencies such as adverse weather. Each person had a personal emergency evacuation plan (PEEP's) in place. These were readily available and consisted of essential information about support required by each person in the event of an emergency, ensuring the continuity of care delivered to people.

People were protected from the risk of infection because staff were aware of the prevention and control of infection guidance. The service was clean and hygienic. There were cleaning schedules in place, and staff were provided with policies and procedures together with recent national guidance of infection control in care homes. Personal protective equipment, such as aprons and gloves, was readily available when needed and staff had received training in infection control and food handling.

Is the service effective?

Our findings

People's physical, mental health and social needs were thoroughly assessed before they moved to the service. Staff explained how they would take time to build a relationship with people, find out what their likes and dislikes were so they could tailor their care to each individual. A member of staff told us, "The thorough assessment of [person's] needs allowed us to produce a comprehensive care plan and a behaviour support plan basing on the information from his previous placement".

People and one person's relative praised staff's skills and knowledge. One person said, "I like staff. They know what they are doing". A relative of a person told us, "It is apparent in talking with staff, that they are well-trained, highly devoted and motivated to provide the highest standard of care to each individual resident".

All new staff had undertaken induction training which included the completion of the provider's training in relevant areas. Newly employed staff members shadowed more experienced staff for two weeks or until they felt confident to work unsupervised. Staff's competencies were assessed in areas such as safe handling of medicines and the completion of a probationary period was obligatory for all new staff. This ensured each staff member had the appropriate knowledge and skills to carry out their role effectively. A member of staff told us, "During the induction I was introduced to the service users, I was provided with training and shadowing opportunities. The shadowing lasted almost a month and then I started working on the floor. It did help me a lot as I was completely new to healthcare".

People were supported by staff who had been appropriately trained. Training was up-to-date and staff had received additional training specific to the needs of people they supported, for example training in communication skills, epilepsy and learning disability. Staff members also stated they had easy access to training and were actively encouraged by the management to complete both mandatory and specialised training. A member of staff told us, "We are following the best practice in relation to training. We have regular refreshers and plenty of face-to-face training".

Staff received regular supervision and yearly reviews of their work performance. This helped the provider review staff development and day-to-day practices. Records were detailed and included discussions about people using the service, day-to-day issues in the home and personal development needs. Staff told us they felt well-supported by the registered manager and had good opportunities to learn and develop their skills further. A member of staff told us, "We have our supervision meetings every six weeks to discuss issues related to the service. On top of that we have an annual supervision. I find them both very useful as they define our goals and help us to improve the quality of care provided to our service users".

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. We checked whether the service was working within the principles of the MCA. Staff understood

and received regular training in the MCA. A member of staff told us, "The MCA is about people being able to have capacity to make choices unless stated otherwise. Every decision undertaken on behalf of people must be in their best interest".

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had identified people who they believed were being deprived of their liberty as the front door and the gates to the service were kept locked and people were unable to leave unsupervised for their own safety. The registered manager had made DoLS applications to the supervisory body and regularly tracked the progress of the applications.

People were involved in making decisions about the environment, both the decoration of their own rooms and of communal areas. People's bedrooms were personalised and decorated to people's individual taste. The service had outdoor space for people to sit and enjoy the garden.

People were able to access their kitchen when they wanted, and were free to choose what they wanted to eat and drink. Menus were planned with the involvement of people. These were varied and included a range of choices throughout the week. People were encouraged to participate in the preparation of food and involved in shopping for food. People's food and fluid intake was monitored to make sure they had enough to eat and drink. One person had been identified as being at risk of malnutrition. A detailed plan to assist them to gain weight had been drawn up including the use of Malnutrition Universal Screening Tool (MUST). This had proven to be very successful and they were close to achieving their target weight.

People were supported to access healthcare services when needed and staff provided people with information about their care and support options. We saw people had appointments with GPs as well as appointments with psychologists, psychiatrists and a learning disability team. People's records contained hospital passports which included personal details about people and their healthcare needs. The service used health action plans which detailed professionals involved in people's care, information relating to the administration of medicines, communication and current treatment. Information was regularly updated and the document could be used by people for hospital admission or for healthcare appointments to explain to healthcare professionals how they liked to be looked after.

The service used a variety of communication methods to ensure people felt involved and understood information about their healthcare and treatment options. For example, health action plans were produced in an easy to read format so people could read and consent to them.

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person told us, "I like staff. They are nice to me". One relative of a person said, "The staff are all so friendly, kind and patient with all the residents".

Staff respected people's privacy and dignity. We observed care was offered discreetly in order to maintain personal dignity. People's privacy was protected by ensuring all aspects of personal care were provided in the privacy of people's own rooms or in the bathrooms around the home. Staff knocked on doors and waited for a response before entering people's rooms. A staff member told us, "I always make sure the windows and doors are closed and I seek the person's consent".

People were encouraged to be as independent as possible. Staff knew the level of support each person needed and realized what aspects of their care people could do themselves. Staff members were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely. A member of staff told us, "I let people do as much as they are able to do in order to maintain their independence".

People were supported to make decisions about their care and this was achieved by regular meetings with people's keyworkers. A keyworker is an allocated member of staff who has particular responsibilities for one person or a small group of people. People were able to give feedback to their keyworker on what they liked about the service and what they would like to change. During the inspection we saw people making choices about their day-to-day life, for example, one person decided to spend some time in their room and another chose to go to the garage shop to buy themselves some wordsearch books. A member of staff told us, "We are involving service users in their care. They may choose an activity, clothing or they can choose what they want to be on the menu".

Care records were centred on people as individuals and contained detailed information about people's diverse needs, life histories, strengths, interests, preferences and aspirations. For example, there was information about how people liked to spend their time, their food preferences and dislikes, what activities they enjoyed and their preferred methods of communication.

The equality and diversity policy was available at the service. People's cultural and religious backgrounds as well as people's gender and sexual orientation were recognized at the initial assessment stage and respected within the service. Staff received training in equality and diversity.

There was clear guidance in people's care records about how people communicated and how staff should respond. During the inspection we saw that staff were following the guidance and effectively communicated with people. A member of staff told us, "The best way to communicate is to listen to them and give them time to communicate as per [person's] guidance. They feel better once they have passed the message to you".

All relevant information concerning people was made accessible to them. For example, the complaints

policy was displayed in the communal area in an easy-to-read format. Care records such as health action plans and communication passports included pictures and plain language to help people understand the information.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified people who were important to the person. Staff supported people to maintain their relationships, which was confirmed by people themselves and by a relative of a person.

Confidential information, such as care records, was kept securely and was accessed only by staff authorised to view them. When staff discussed people's care and treatment, they were discreet and ensured their conversations could not be overheard.

Is the service responsive?

Our findings

At our previous comprehensive inspection in February 2017 we had identified a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not always been provided with sufficient opportunities to engage in activities.

At this inspection we found the provider had taken actions to implement the required improvements. People were encouraged to participate in the activities they enjoyed. For example, one person was fond of going to the day centre, cooking, going for walks and carrying out house safety checks. They told us, "Yes, I go out very often. I have just asked staff on shift and we are going to the garage shop". A relative told us, "There are many activities arranged for them as a 'family group' and for individual outings or activities. Visits to the zoo, holidays at the seaside happen regularly. There are various day trips for walks in country parks for example. Evening activities also happen regularly, such as discos, pub evenings with darts, pool or snooker, and with karaoke being a particular favourite. During the day activities include attending the day centre for art classes and other various activities are always available. Staff always play games with the residents, like chess, cards, dominoes, Jenga, etc. or watch a film or football or other sports together, just like a real family".

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care were discussed regularly at shift handovers to ensure support and care delivered to people was appropriately adjusted. Staff told us it was crucial for all staff to be aware of any changes to people's care needs to ensure a consistent approach. We saw evidence staff knew people well and any changes in people's health and well-being were addressed immediately, with health care professionals involved in people's care.

People received care that was personalised to them. People's records gave staff the information they needed about people's history, preferences, interests, goals and aspirations. Some of the life histories included in the care plans were particularly detailed so staff had a good understanding of people's background and interests, even if people's ability to communicate was limited. This enabled staff to respond appropriately to people's wishes and treat them as individuals. Care plans were outcome-focused. For example, one person's goal was to meet their friend at least twice per week while another person's goal was to have a nutritious and balanced diet. Staff helped people in meeting such goals by involving people in their care, explaining to them what was happening and providing them with necessary support.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke with the registered manager about how they ensured information was accessible to all people living at the home. They told us and records confirmed that people were provided with information in a format they were able to understand. Care plans and complaints policy were produced in an easy-to-read format and care plans specified people's preferred methods of communication.

We asked a member of staff how would they recognise it if people who had communication difficulties were

unwell or in a pain. A member of staff explained, "[Person] struggles with speaking, however, he points at his body while in a pain. [Another person] makes noise and touches himself, he would also answer our questions with thumbs up or down".

People and one relative of a person told us they knew who to make a complaint to if they were unhappy, but the relative had emphasized the fact they had never needed to do so. No complaints had been received in the last 12 months. Staff told us that if such a need arose, they would support people to make an official complaint. A member of staff told us, "We know when service users are unhappy and they want to complain. [Person] confronts a member of staff straight away while [person] will go to the management and tell them".

We discussed various aspects of end of life care with the registered manager. They told us that even though it was a sensitive subject and might distress people using the service, it was going to be discussed with them with help of advocacy services where appropriate.

Is the service well-led?

Our findings

During the inspection we found that the service had not always followed the provider's policies. Contrary to the provider's policy, some assessments regarding high-probability risks had not been reviewed within the last three months. However, there was no negative impact of the above-mentioned shortfall on people.

We recommended that the provider review risk assessments in line with their policy.

There was 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.

People and their families told us they felt this was a well-led service. One person said, "I like [the registered manager]. She is really good". One relative of a person told us, "The residence is very well run and organised by [the registered manager]. She keeps me well informed and we have a very good relationship".

We met the registered manager and the director of care and spoke about the work they had done introducing their vision and values to staff to improve the experience of people using the service. The registered manager told us about the changes she had made within the last 12 months and about her plans for the future. This included refurbishment of the kitchen and introducing a wide range of activities provided to people.

Staff told us the management team continued to encourage a culture of openness and transparency. Staff also told us the registered manager promoted an 'open door' policy which meant that staff could speak to them if they wished to do so, and worked as part of the team. Staff assured us they felt comfortable speaking with managers and felt listened to and supported. A member of staff told us, "When you complain about something the management is acting on it".

The provider had clear values which were promoted by the management team to all staff. The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live as independently or with as little support as possible. A member of staff told us, "Our main values are to support, care and to make sure that service users, visitors and carers are happy, safe and that people lead a full and active lifestyle within their local communities".

The provider proactively sought people's views and took action to improve their experiences. The provider's quality assurance system included asking people, relatives and visitors about their opinion on the service. People were asked for their feedback during regular meetings with their keyworkers. We saw people's opinions on the service was positive. The questionnaires asked people's relatives what they thought of the food, care delivered to people, staff, the premises, the management and people's daily living experience. The provider took action to improve the quality of the service based on the results of their surveys. For example, some of the relatives had complained about the condition of the driveway. The provider had

liaised with contractors and obtained three quotes by the time of our inspection.

Staff told us they were actively involved in the running of the service. The management constantly encouraged staff come up with ideas for new activities for people to spend their free time. A member of staff told us, "Whenever we want to introduce new activities, we are welcome to do this. We are involved in shaping the service".

The provider worked closely with social workers, referral officers, the learning disability team and other health professionals. Relevant support helped people continue to live their lives actively and safely. When needed, people were referred to the most appropriate services for further advice and assistance.

The service worked closely with the local safeguarding team to report and investigate any alleged abuse. Records confirmed accidents, incidents and safeguarding concerns were monitored centrally and any lessons learned were discussed during both management and staff meetings to ensure the continued improvement of the service.

Staff meetings were held monthly and helped to share learning and best practice so staff understood what was expected of them at all levels. Minutes included details of people's general well-being and guidance for staff concerning the day-to-day running of the service. The minutes were made available to all staff members to ensure everyone had a consistent message. A member of staff told us, "We hold regular team meetings and management meetings with the management and seniors. We discuss what needs to be put in place to improve team working". Staff also used a communication book and daily planners to remain informed about any changes to people's well-being or other important events.

The registered manager told us and records confirmed that they checked the quality of the service regularly as they were in day-to-day control of the service. Effective governance systems, such as regular audits, had been undertaken and had enabled the registered manager and staff to continuously improve the service. The audits included areas such as health and safety, medicines, and infection control.

The registered manager understood their responsibilities in line with the requirements of the provider's registration. They were aware of the need to notify the CQC of certain changes, events or incidents that affect a person's care and welfare. We found the manager had notified us appropriately of any reportable events.