Eastfield Farm Residential Home Limited

Eastfield Farm Residential Home Limited

Inspection report

Eastfield Farm
Southside Road
Halsham Hull
Humberside
HU12 0BP

Tel: 01964671134

Date of inspection visit:
14 November 2016
15 November 2016

Date of publication:
13 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 14 and 15 November 2016 and was unannounced. This meant the registered provider and staff did not know we would be attending. The service was last inspected on 28 and 29 July 2015 and concerns were raised in relation to the number of staff who had received training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service was complaint with all other regulations at that time.

Eastfield Farm is a renovated farm house situated in open countryside in the village of Halsham, close to the seaside town of Withernsea in East Yorkshire. The service was originally built to provide residential care to the farming / rural community in an environment they were used to. It offers care for up to 26 older people, some of whom may be living with a dementia type illness. On the day of the inspection there were 23 people living at the service.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). 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.

Medicines at the service were not well managed, and people did not always receive there medicines safely and in line with their prescriptions. Concerns were raised in relation to storage, recording, administration and auditing of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was able to demonstrate they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the Court of Protection. However, we found that Mental Capacity Act (2005) guidelines were not always followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a quality assurance system in place, but the system was not effective in assessing, monitoring and improving the quality and safety of the service. We also found record keeping at the service to be inconsistent. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we asked the provider to take at the end of the report.

The registered manager had not informed the CQC of all significant events. This meant we could not check that appropriate action had been taken. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported. However, not all care plans were fully reflective of people's current needs. We made a recommendation about this in the report.

Accidents and incidents were recorded and people's relative's told us they were kept informed of these. However, when people had experienced repeated falls the response taken by the service was not always thoroughly documented.

People enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day. Food and fluid charts were being used to monitor nutritional intake, although record keeping in relation to these charts was inconsistent.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the service deemed essential, such as safeguarding, medication and MCA.

We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following appropriate recruitment and selection processes.

Assessments of risk had been completed for each person and plans had been put in place to minimise risks for most people. The service was clean, tidy and free from odour and effective cleaning schedules were in place.

People told us they were well cared for and we found people were supported to maintain good health and had access to services from healthcare professionals. Visitors to the service spoke highly of the care provided by the service.

People were offered a variety of different activities to be involved in. People were also supported to go out of the service to access facilities in the local community.

The registered provider had a complaints policy and procedure in place and there were systems in place to seek feedback from people and their relatives about the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

Accidents and incident were well recorded. However, one person had experienced repeated falls and there was a lack of recorded evidence to show what action had been taken by staff.

Staff displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm. However, not all information about safeguarding concerns had been submitted to the safeguarding team.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the court of protection. However, we found the Mental Capacity Act (2005) guidelines had not been followed.

People had access to adequate food and drinks, but this was not always well recorded by the staff

Staff received an induction and training in key topics that enabled them to carry out their role.

People's health needs were met. People who used the service had access to additional treatment from healthcare professionals, when needed.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection. Relatives spoke highly of the care staff and the care they delivered.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people, although the care plans were not always reflective of people's current needs.

People had access to activities and were able to access the local community.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a quality monitoring system in place; however, it was not effective and failed to identify areas of concern.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Eastfield Farm Residential Home 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 was planned to check whether the registered 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 14 and 15 November 2016 and was unannounced. On day one of the inspection the inspection team consisted of one adult social care inspector and one pharmacy inspector. On the second day of the inspection, one adult social care inspector completed the inspection.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the service.

The registered provider was not asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five members of staff, the registered manager, the proprietor, five people who used the service and four people's relatives. We spent time observing the interaction between people who lived at the service, the staff and any visitors.

We looked at all areas of the service, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for five people, people's medication records, handover records, supervision and training records for three members of staff

and quality assurance audits and action plans.

Requires Improvement

Is the service safe?

Our findings

We saw that all staff had completed training in the administration of medications and this enabled people to have access to medication across both day and nights shifts. This was confirmed by our checks of the staff training plan and staff training files. Staff also told us that regular medication competency checks were carried out as part of ongoing supervision.

We looked at four Medicines Administration Records (MARs) and spoke with the senior carer responsible for medicines, as well as the registered manager. Medicines were stored in a treatment room, however on the day of our visit the treatment room door was unlocked and the keys had been left in the medicines trolley. This meant access to medicines was not restricted to authorised staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. The records we reviewed did not reflect the stock held in the cupboard because the register showed three medicines were in stock when they had been returned to the pharmacy for destruction. In addition, staff did not routinely carry out balance checks of controlled drugs.

Room temperatures where medicines were stored were recorded daily and were within safe limits. We checked medicines which required cold storage and found staff only recorded the current temperature of the medicines refrigerator, which is not in accordance with national guidance. In addition, temperatures had not been recorded every day. Unwanted medicines were disposed of in accordance with waste regulations.

Staff did not routinely reconcile people's medicines when they moved between care settings. For example, one person had recently been discharged from hospital and the GP had stopped one medicine. However, we saw this person had continued to receive the medicine for 19 days. This meant there was a risk the person could have come to harm by continuing it when the doctor had intended it to be stopped. We also found some records did not contain the person's allergy status. This increases the risk of someone receiving a medicine they are allergic to.

There was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only as and when required. For example, one person was prescribed a medicine which can be used for different symptoms, but there was no information to describe why the person might need the medicine or the desired outcome of the treatment. In addition, staff did not record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. Where one or two tablets had been prescribed, staff did not record the number of tablets they had given which meant records did not accurately reflect the treatment people had received. We also found a number of gaps in administration records where staff had not signed or recorded the reasons for not administering medicines.

People did not always receive their medicines as prescribed. One person was prescribed a pain relief patch which should have been changed every seven days. We found this had been applied one day late on one occasion. This increases the risk of the person experiencing pain or discomfort. Another person was

prescribed medicines for Parkinson's disease. We found they had not been given their lunchtime medicines because their morning medicines had been given late. This increases the risk of the person experiencing unpleasant symptoms. Two other people had been given medicines which were prescribed to be taken before food, however, they had received these medicines after they had eaten their breakfast. This may have reduced the effectiveness of these medicines.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We viewed safeguarding records and saw that safeguarding concerns were recorded on a safeguarding consideration log. However, they were not always reported to both the local safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents.

We found an allegation of abuse had been made against a member of staff. The registered manager had investigated this thoroughly and the person making the allegations had indicated that they did not want the concerns taking any further. However, the local safeguarding team had not been contacted and no notification had been received by the CQC. Following the inspection, we asked the registered manager to discuss this concern with the local safeguarding team. This was a breach of regulation and has been addressed in the well-led section of this report.

We spoke to staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to either the senior member of staff on shift, or the registered manager. They also told us they knew how to escalate the concerns if they felt the issue had not been appropriately addressed. One member of staff told us, "If I saw anything of any concern then I would speak with the manager or could always contact safeguarding team or the CQC."

We looked at how risks were managed. Care plans identified risks and described in detail how risk would be minimised by the actions of the service and through structuring the environment. For example, we saw that two people had crash mats in place as they had fallen out of their beds on occasions. We saw that the use of bed rails had been considered; however, they were deemed unsuitable as the person could try to climb over them, potentially increasing the risk of more serious injury. We saw that incidents and accidents were accurately recorded, investigated and action taken where necessary.

Accidents and incident were recorded and audited on a monthly basis. This helped ensure any patterns or increased rate of incidents were identified and action could be taken to reduce these. We saw that when people suffered repeated falls then this information was recorded in a falls dairy that included information such as the date, time, description of fall, any injury that was sustained and the action taken. For example, when people sustained head injuries, a member of staff had contacted the appropriate service to seek advice. We noted that the accident / incident document did not provide an opportunity for staff to record what lessons had been learnt and how they intended to reduce the recurrence of incidents in the future.

We reviewed the falls records and found that two people had experienced a high number of falls in the last year. We checked to see what action had been taken in response to these falls and saw the effectiveness of the response was inconsistent. For example, we saw that following a number of falls for one person staff had discussed this with the person's GP, who had amended their medication in response. We saw that another

person had been referred to the falls team following repeated falls and we also saw equipment such as crash mats and sensor mats were in place to protect people from falls in their own bedrooms. However, we found that one person had suffered 13 falls in the last year, two of which had resulted in admission to hospital. These had all been thoroughly recorded. However, there was no evidence of the action the service had taken in response to this. We also found there was no clear guidance in place to advise staff when a referral to the falls team should be made. We discussed this with the registered manager, who assured us that contact had been made with the person's GP; however, it was clear this had not been recorded.

We asked people who used the service and visitors if they felt there were enough staff on duty. One person who lived at the service told us, "There are enough staff, but the shifts are very long. I think that most of them have had enough by the eight hour mark" and, "The morning shift could sometimes do with an extra pair of hands, especially when they are having a busy day."

We discussed staffing numbers with staff. They told us, "There's usually enough staff, however if somebody becomes distressed then it can feel a little bit stretched, until they have settled back down." Another said, "Yes there are enough staff, we can be pushed for time sometimes, but it varies from day to day. I love the residents; I know that everybody is clean, everybody is dry, everybody is fed and looked after, but I just wish we could do more with them in terms of activities."

We observed that there were sufficient numbers of staff on duty to enable people's needs to be met. There was always a staff presence in communal areas of the service and during the inspection we found that people did not have to wait for attention. The registered manager told us that the standard staffing levels on day shifts were three care workers plus one senior care worker. Overnight there were two members of staff on duty with a member of the management team 'on call'. The registered manager and deputy manager were on shift in addition to care staff. We checked the staff rotas and saw that these staffing levels had been consistently maintained. In addition to care staff, there was a cook and a domestic / laundry assistant on duty each day and a maintenance person from Monday to Friday. This meant that care staff were able to concentrate on supporting people who lived at the service.

We looked at the recruitment records for three staff members. We found that application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them.

We saw care plans contained risk assessments that were individual to each person's specific needs. For example, one person had bed rails in place to prevent them from falling from their bed. We viewed their care plan and saw that the use of bed rails had been assessed to ensure they were safe for the person to use. We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas services, water temperatures, electrical items and all lifting equipment including hoists and the stair lift. We saw that a suitable fire risk assessment was in place and regular checks

of the fire alarm system, fire extinguishers and emergency lighting were carried out to ensure they were in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We found the service to be clean, tidy and free from odour. Regular deep cleaning was undertaken by the services domestic staff and we saw that there was detailed information available for staff on hand washing and what to do in the event of an outbreak or suspected outbreak of an infectious disease. We found that the service was clean and tidy, that all chairs appeared clean and comfortable and that carpets and flooring were generally in good condition. We noted one carpet at the rear of the property was in need of replacement. The registered manager confirmed this had already been identified and was next on the list of environmental improvements. A relative told us, "The home is always nice and clean, there are never any odours that you can get in some places." Another said, "It always feels nice here, no odours and clean."

Requires Improvement

Is the service effective?

Our findings

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. At the time of the inspection, there were no DoLS authorisations in place and the service was waiting for assessments and approval for six applications they had submitted.

We saw that the service was following MCA guidelines in some instances but not others. For example, we saw that one person had their medication administered covertly. Covert administration of medication is the administration of medication to people in a disguised format without their knowledge or consent. For example, it can be hidden in food or in a drink. We saw that a best interest meeting had taken place and there were clear instructions in place regarding how medication should be administered.

We also found examples where the MCA guidelines were not being followed. For example, we viewed care plans and saw that capacity assessments had taken place on admission and when people deteriorated in relation to general care planning. However, we saw that when people were assessed as lacking capacity to consent to their own plan of care, they were still being asked to sign the consent form. On other occasions we saw that only a member of staff had signed the care plan and there appeared to be no consultation with either the person receiving the care or their chosen representative.

We found that one person using the service had a risk assessment in place for their 'challenging behaviour' to enable staff to provide them with personal care. From the care records we viewed we saw that the person's community psychiatric nurse (CPN) had advised the service that it was in the person's best interest for personal care to be carried out by staff even when the person was displaying distressed or anxious behaviour. The CPN had also informed the person's GP of this type of intervention. However, following conversations with staff and the registered manager it was apparent that although the care plan stated that, 'two to three staff to work together to wash and dress me as quickly and efficiently as possible to minimise the length of my distress', staff were actually using low level physical restraint to enable them to complete personal care tasks. We found no clear plan was in place for staff to follow and no best interest meeting had taken place. Best interest meetings are held when people do not have capacity to make important decisions. Health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. This showed that the registered manager and staff had not followed MCA guidelines. We saw staff had completed training in 'challenging behaviour' but this did not include training on the low level hold they were currently using. We discussed this with the registered

manager and they immediately arranged for appropriate training to take place. This training is scheduled for January 2017.

This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection completed on 8 December 2014, we found that not all staff had received training in relation to the MCA and DoLS. At this inspection staff told us they had completed MCA training and records we viewed confirmed this. We were told that some people who lived at the service could display distressed and anxious behaviour and staff told us they had received training on de-escalation and distraction techniques that enabled them to effectively manage this in most instances. The staff we spoke with were able to describe the techniques they used to help deescalate these episodes of behaviour. One member of staff said, "We can cope, I've just done training on it. People respond to different approaches and if somebody doesn't want our support another member of staff will try." A relative told us, "[Name] doesn't always like to get a bath or a shower, but I know [Name of staff member] can sometime persuade them to." This showed that staff knew to try different approaches to ensure care was provided.

We looked at the induction and training files of staff to check that their induction would give them the necessary skills and knowledge to care for people who lived at the service. We saw that newly recruited members of staff were required to complete an induction covering service specific topics that focused on elements such as the service's fire procedure and the action staff should take in the event of an emergency. New staff were also required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives and covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Following the completion of the Care Certificate, staff were enrolled on the National Vocational Qualification (NVQ) level 2 in care. NVQs are now known as Quality Credit Framework (QCF) or diplomas and are nationally recognised work based training courses. We were also told that staff were given the opportunity to shadow more experienced staff members before they were included on the rota. The staff we spoke with confirmed this.

We viewed training records and saw that staff completed a variety of training in topics such as safeguarding, moving and handling, fire awareness, health and safety, infection control, equality and diversity and dementia awareness. This was delivered through a distance learning programme and via face-to-face training delivered by external training providers for topics such as moving and handling. All of the people we spoke with felt the staff had the necessary skills to effectively carry out their roles. One person told us, "I think all the staff seem competent. I have seen them moving and handling and they all look well trained."

Staff told us they felt well supported. One member of staff told us, "I have supervision every 4-6 weeks. I feel they are useful, I can give my opinion and if I raise any concerns these area acted on." Supervision records we viewed supported this. We viewed staff meeting records and saw these were held quarterly. We saw a range of issues were discussed and this included any changes to the service that could affect the staff team, training, the service users and also any issues or concerns that had been raised during team leader meetings. For example, we saw that medication audits had identified that there were a number of errors in relation to the recording of medicines and staff were reminded of the importance of these legal documents.

We observed lunchtime and saw tables were set with cutlery, condiments and crockery. People were offered a choice of hot and cold drinks with their main meal and following it. Lunch consisted of a soup starter, the choice of two hot meals and dessert. If people did not want either of the choices, the cook would offer an alternative. We saw staff showed people a choice of each meal at the table to enable them to choose the

meal they wanted. On both days of this inspection, people who required assistance with eating and drinking received this in a patient and dignified manner. On the first day of the inspection we noted that improvements could be made to the dining experience. We saw that televisions were not turned off during lunchtime, tables were not set with tablecloths and people did not receive their choice of drink until everybody had been served their main meal. We also saw that the white board in the dining room did not display the day's menu. On the second day of the inspection we saw that the registered manager had taken action to ensure these issues had been addressed.

People who lived at the service told us they enjoyed the food and were given a choice. One person told us, "The food is quite good; you get a good choice, although the vegetables are a bit over cooked." Another said, "I think the food is alright. I like the beef and Yorkshire pudding, a proper farm meal." The relatives we spoke with were complimentary about the food. Comments included, "The staff have really encouraged [Name] to try different foods. Previously they would only eat salads, but they tried the chicken korma the other day and they said it was ok.", "The food is brilliant and they can pick and choose the meals they want, they get given a menu" and, "[Name] really wasn't eating very well, but they have got them some special drinks in and they have started putting weight on again."

We saw that people's weights were monitored and recorded in their individual care files and we were told that they were recorded in a service weight file. However, we noted that the quality of recording was inconsistent. There were a number of gaps in people's individual weight records, the Malnutrition Universal Screening Tool (MUST) had not been calculated and there had been no entries since August for several people. We asked to view the service user weight file; however, staff were unable to locate this. We noted from one person's weight record that they had lost over 10% of their body weight in a five-month period. We discussed this with the registered manager who indicated that the weight recorded in August was possibly incorrect. The person was weighed whilst we were at the home and the person's weight was almost identical to the weight recorded in April. As it was clear that the person's weight had been incorrectly recorded, we requested that all people living at the service were weighed to ensure the service held an accurate weight record for all people living there.

We saw that food and fluid charts were in place for people who were deemed at risk of weight loss. However, we found that the recording of food and fluid was not always accurately completed and the fluid intake for people was not always tallied. We also saw that there was no guidance available for staff to know how much fluid each person should be consuming and what action was needed if the person fell below or above that level. We discussed the recording issues with the registered manager who told us they reminded staff on a regular basis to ensure all records were accurately maintained. We viewed staff meeting records that supported this. The registered manager told us they would have to consider another approach with staff to ensure that records were completed accurately. We have addressed this in the well-led section of this report.

People's health needs were supported and were kept under review. We saw evidence that individuals had input from their GPs, district nurses, chiropodist, optician and dentist. Where necessary, people had also been referred to the relevant healthcare professional. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). Relatives we spoke with told us that the staff were quick to seek support when needed. Comments included, "They are always quick to call the GP when needed. [Name] has been in pain and they have got them some strong pain killers that seem to be working", "[Name] had some problems with swollen legs and they contacted the district nurses who are now treating this" and, "They have sorted [Name] with some new glasses which has helped." A visiting health care professional told us, "They are generally very good at escalating any concerns and when we set up a plan of care it usually followed, although some of the staff are better at this than others" and, "People seem really settled here, I have no concerns."

Good

Is the service caring?

Our findings

All of the people we spoke with who used the service told us that they felt the staff were kind, caring and respectful. Comments included, "Staff are patient, tolerant and do their best", "Staff are respectful and encouraging to all residents" and "I am very happy in terms of care. The staff are good and always ask permission before entering my room." The relatives we spoke with were also very positive about the staff team. Comments included, "The staff are very friendly and very approachable. They all seem really nice",, "The staff are brilliant. I know [Name] likes some more than others, but that's just human nature", "The staff are great, really friendly and they have really taken to [Name]", "Overall I'd say they were brilliant, they are always there to help" and "The staff area all very friendly."

We observed staff interacted positively with the people who lived at the service. They showed a genuine interest in what they had to say and responded to their queries and questions patiently, providing them with the appropriate information or explanation. We saw people who lived at the service approach staff with confidence; they indicated when they wanted their company and when they wanted to be on their own and staff respected these choices. One member of staff said, "I don't go out when it's my turn for a break, I prefer to make a cup of tea and have a good catch up with the residents."

Staff told us they treated people with dignity and respect. One relative told us, "The staff are respectful, they knock on the door before they enter." Another said, "I saw one lady had been incontinent and the staff were really quick to sort it out. They didn't make a fuss, just took her away to get cleaned up."

Staff were aware of people's needs and knew when to intervene when people showed distressed or anxious behaviour and when to leave them to settle on their own. One person who lived at the service told us, "The staff know when to walk away and they know not to argue when people are distressed." A relative said, "I know [Name] can be challenging, but the staff are really patient and have learnt how to manage them" and, "Staff have learnt that if somebody can sit with [Name] in the morning whilst they are coming around, then they generally have a better day." They also added, "They all know [Name], they know when to have fun and when they're best left alone." A health care professional told us, "The staff know people really well, they know their needs."

People's independence was promoted. One member of staff we spoke with told us how they had provided some short term intensive support with one person who lived at the service. They said, "[Name] is registered blind and they sometimes struggled to find their way to the toilet. I spent almost two full days with them when I first started and taught them to find their way to the toilet by themselves. They can now do this independently which has freed up staff to support people with greater needs." One person who lived at the service said, "The staff leave me to get myself up in the morning, I'm used to getting up from my farm days. If I need help with anything I just have to ask them."

People told us they were given a choice about how their care was provided. They told us they were able to choose what time they got up in the morning and what time they went to bed. They told us they were given a choice of where they sat and whom they spent their time with and were provided with a choice at

mealtimes. Staff explained how they ensured that even when people were unable to effectively communicate they were still offered a choice. For example, one member of staff explained, "Sometimes people can get overly confused if you give them too many choices. You get to know people's preferences, so I usually offer a choice of two or three things that I know they like. They will soon let me know if they want something else." A relative said, "There is a real family atmosphere to the home, it's very relaxed, unregimented."

Relatives who we spoke with told us they were free to visit people living at the service as often as they liked and they were kept informed of any issues regarding their family member. They said they normally spoke with the registered manager or staff when they visited, but would receive a telephone call if anything unusual or urgent occurred. One relative told us, "I come once a week, but can come as often as I want. They have invited me to the Christmas dinner." Another told us, "I visit every week, I bring the grandchildren in, I bring the dog and we are always made to feel welcome." We saw that positive relationships were encouraged and found that some people had developed friendships with other people living at the service. We saw that people chose who they sat with and this enabled them to find things they had in common. One relative told us, "[Name] has made friends with another lady; they sit opposite each other and have lots of good banter."

Some staff had completed training in equality and diversity and this training was to be rolled out to all staff. Discussions with the staff revealed there were people living at the service who had different needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that people from all backgrounds were welcome at the service and that steps were taken to ensure that all people were treated with dignity, respect and without discrimination.

Requires Improvement

Is the service responsive?

Our findings

We saw that pre-admission assessments had been completed prior to people moving to live in the service on either a permanent or temporary basis. This ensured that the service was able to meet the needs of the person and to also assess any impact there could be on staffing levels. An initial assessment was undertaken which identified people's support needs and care plans were then developed outlining how these needs were to be met. Risk assessments were also developed for those aspects of care where potential risk was identified.

Care plans included information regarding peoples likes and dislikes, daily routine and life histories. We were told that this information was collected either from the person themselves or from a family member or friend. This provided staff with insight into what people used to do for a job, what hobbies they enjoyed and what things and people were most important to them. We saw evidence that people were consulted with regards to the content of their care plan following admission. We noted there was no evidence to show that changes to the plan of care had formally been discussed with the person or their advocate and asked the registered manager to ensure this was included following future reviews." One relative told us, "Yes they asked about [Name]'s likes and dislikes and I have attended reviews in the past but not recently." Another told us, "They asked me for my input. The CPN is coming soon and they have asked me to attend the review. If I wasn't involved then I would be asking why."

We saw that a review of each care plan was scheduled each month; however, these were not always completed, nor did it guarantee that care plans were fully reflective of people's current needs. For example, we were told that one person was at high risk of absconding from the service. We viewed their care plan and found there was no mention of this in their care plan. From discussions with staff they were able to tell us how previous episodes of absconding had been managed. However, they expressed concern that they might not be able to physically support the person back to the service, especially if the person left in cold or bad weather. We discussed this with the registered manager and explained that a clear plan needed to be in place that all staff could follow if the person did manage to leave the service unaccompanied.

We recommend the register manager seeks advice and guidance on the accurate maintenance of care files.

The service had a monthly activity booklet which enabled people and their relatives to see what activities were available on each day of the month and also informed people when any trips out had been arranged. For the month of November we saw the activities on offer included hair and beauty, exercise classes, arts and crafts, film afternoons, sports afternoons, bingo, dominoes and baking. A member of staff told us, "We do other things, we had a beach day in the summer and had big tubs of sand for people to build sandcastles. There is a keep fit class and singers come in once a fortnight to entertain people. Some staff will do karaoke and there is also a ukulele band that comes in." People were occasionally offered the opportunity to go for a day out or a trip to the shops.

The relatives we spoke with told us they saw activities happening on a regular basis. One told us, "They took [Name] to Hull Fair and they take [Name] out for a ride in the car which they enjoy" and, "They enjoy the

music sessions but they're not a big fan of the exercise classes, but they are 92." Other comments included, "Staff keep them busy but [Name] doesn't tend to get involved", "They include [Name] in any activities that are going on. They were planting geraniums and they got them involved", "I still take [Name] out from time to time. We use the wheelchair and then we get to see a bit more than if we are all walking" and, "They had a great beach party, everybody loved it."

People who lived at the service told us, "I get involved in the activities when I can. I enjoy the Bingo and the keep fit as I have always been very active." However one person told us, "Yes, there are activities, but it would be nice if they did some more. One member of staff told us, "It would be better if we had a designated activity coordinator as staff don't always have the time to put activities on, on top of all the other tasks we have to do." Another member of staff said, "I think there could be more activities, but time is sometimes an issue. When the right team is on, we will make time for activities." The registered manager told us they would discuss this with the staff team, to ensure that a varied activity programme was always on offer.

The service had policies and procedures in place to manage any complaints that they received. A copy of the complaints procedure was available in the reception area of the service and people living at the service and their families were provided with a copy in the service user guide. We saw that complaints were fully investigated and the outcome was recorded in the complaints file. There was evidence that appropriate action had been taken in response to the complaints received. We saw the last complaint was received on 9 November 2016 and came from one of the people living at the service. We discussed this with the person and found that they had been satisfied with how the complaint was managed and also that the outcome had resulted in an improved service for them. We saw this had been signed off by the registered manager, although this had not been signed off by the complainant. The registered manager agreed to ensure that this would be included on a revised complaint document.

People we spoke with knew how to make a complaint. One relative told us, "If I have any concerns or issues then I speak with staff or [Name of registered manager]. [Name of registered manager] is quick to address any issues and has sorted any problems out." Another said, "The staff are very approachable. If I had any concerns I can discuss it with any of them." A third relative told us, "If I had any concerns I would speak with [Name of manager]." One person who lived at the service told us, "I've never been unhappy. If I was I would speak with [Name of registered manager] or whoever was in charge that day."

Other opportunities were available for people to offer feedback on the service they were receiving. We saw 'Resident' meetings were held and we viewed the notes from a recent meeting held on 9 November 2016. Different topics were discussed, including menus, Christmas activities, Christmas shopping, staffing and annual surveys. We viewed the previous minutes from meetings that were held in May and February and saw that when issues were raised these were followed up and explanations given in response. Additionally, annual surveys were distributed to key stakeholders including people who lived at the service, relatives and staff. These had only recently been distributed so they had not yet had any returned. One person who used the service told us, "We have just completed an annual survey so will wait for the results."

Requires Improvement

Is the service well-led?

Our findings

Services such as Eastfield Farm that provide health and social care to people are required to inform the CQC of certain events that happen in the service. The registered manager had not informed the CQC of all significant events. This meant we could not check that appropriate action had been taken.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents. We are pursuing this separately with the provider.

We saw audits were carried out to ensure that the systems at the service were being followed and that people were receiving appropriate care and support. These included audits for the environment, medicine systems, care plans, maintenance of equipment, health and safety, infection control and accidents / incidents. We saw that when audits identified any areas for improvement, actions plans were put in place to rectify the problem, however, these were not always completed.

We found that the quality assurance system in place had failed to identify that care plans were not always reflective of people's current needs. This meant that staff did not have access to accurate records in respect of each person using the service, which potentially put people at risk of harm. Food and fluid charts were also not well maintained and the weight records were missing. We also found that safeguarding concerns were not always submitted to either the safeguarding team or the CQC. Additionally the audits failed to identify that the service was not following the principles of the Mental Capacity Act 2005. This meant that people could have decisions made about the care they received, without their consent.

We saw audits were being carried out by the registered manager. However, although one of the proprietors was present at the service five days per week, there was little evidence of oversight at the registered provider level. We discussed this with the proprietor on the second day of the inspection. They explained they were keen for the service to be the best it could be and would discuss with the registered manager how they could be better supported to enable them to focus on their main role as the service's manager. All agreed that this would be of benefit and create a more formal working relationship.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection who had been registered with the Care Quality Commission since September 2013; this meant the registered provider was meeting the conditions of their registration and that there was a level of consistency for people using the service and for staff.

People spoke positively about the care their relatives were receiving at the service. Comments included, "I think it's one of the best homes around. It's very homely and the staff are brilliant", "[Name] took some convincing but once they were here they have settled in straight away. They seem to be able to keep the same staff which provides the continuity that [Name] needs", "[Name] has only been here three months. It

was a difficult decision but they are so well looked after here and they are doing really well, they are really thriving here and are much livelier now. They have brightened up and have their spark back. It's really brought them out of their shell" and, "I would hate for [Name] not to be here, they're part of the place now and the staff have done all they can to make sure they fit in."

Staff told us they felt well supported by the management team. However, they felt that although the registered manager was excellent at managing the service for people who lived at the home, there were times when they needed to be more assertive with staff. Comments included, "I think [Name of registered manager] is a good manager, but could sometimes be a bit stricter with some staff", "They are very good with the residents", "[Name of registered manager] is a good manager, they are very good with the residents, but they need to be stricter" and "[Name of registered manager] is approachable but actions are not always taken. They have a relaxed approach, they are not breathing down your neck, but some staff need that."

We discussed the comments made by the staff with the registered manager. They acknowledged they needed to be more assertive at times and this was an area they were currently trying to develop. The registered manager told us that throughout the inspection they had realised that some things they had requested to be completed had not been done by staff and perhaps a different approach was needed to get the best from the staff team.

It was clear that people using the service enjoyed the company of the registered manager. The office door was open throughout the inspection and people were free to enter and talk with any of the management team. The registered manager explained how much they enjoyed spending time with people and this was supported by our observations. However, they recognised that they needed to spend more time checking that tasks they had delegated to staff were completed on time and that records were kept up to date.

Visitors to the service told us that the registered manager was visible and they could approach them if needed. They also said that the service kept them up to date with any changes pertaining to their relative. Comments included, "I see [Name of registered manager] all the time and speak with them on the phone, they keep us up to date with what is happening", "The communication is good, they always let us know how they are or if they've had a fall", "The manager mucks in, I've not heard anybody say a bad word against her" and, "The manager is approachable, capable and has a good sense of humour. They are extremely patient and I have seen them spend lots of time with [Name of relative]."

We saw that the service's statement of purpose identified the key aims of the service as delivering person centred and quality care, whilst respecting the privacy and dignity of the people who lived at the service. The service also aimed to ensure people remained safe in a relaxed, caring and homely environment. We saw that the statement of purpose was on display, staff were aware of it and they were working towards this to help meet people's needs.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations and we saw that they were appropriately maintained, up to date and securely held. This meant that people's personal and private information remained confidential.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were not protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1)(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. The quality of record keeping at the service was inconsistent. Regulation 17 (1)(2)(a)(b)(c)