R & E Kitchen

Farmhouse Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Farmhouse Care Home is owned by Mr and Mrs Kitchen who are throughout this report referred to as the provider. The home is located in a residential area of Totton, on the outskirts of Southampton and can accommodate up to twenty older persons. The accommodation is arranged over two floors with a stair lift available to access the upper floor. Five of the rooms were shared rooms. There is a small secure outdoor patio area but no garden. The home does not provide nursing care but aims to offer specialist care for older people living with dementia. There were 15 people living in the home when we inspected.

The service had a registered manager. 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 and associated Regulations about how the service is run. The registered manager had recently been absent from the service for a period of three months.

Improvements were needed to ensure that medicines were always stored safely. Where people were prescribed 'as required' medicines, they did not have individualised protocols in place to guide staff as to when to give these. The provider did not have an up to date medicines policy and staff did not have an annual update of their skills and knowledge to administer medicines safely.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff were confident the registered manager would act upon any concerns they raised. However the provider's 'Safeguarding Vulnerable Adults Policy' 'Whistleblowing Policy' needed to be reviewed and updated to ensure they reflected current legislation.

People had risk assessments and where risks had been identified, measures were in place which helped to ensure that the risk was minimised. However, we did note that body maps could be more effectively used to document and plan for how skin damage was responded to.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

The registered manager had plans to introduce a mental capacity toolkit developed by the local authority to help ensure that they and staff were able to fully document how mental capacity assessments had been undertaken and what decisions had been reached in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for

Improvements were planned to update aspects of the premises and make the design and layout of the home more suitable for people living with dementia.

New staff received a service based induction which involved learning about the values of the service, people's needs, key policies and the opportunity to shadow more experienced staff for period of time before they worked independently. Staff felt the training provided was adequate and helped them to provide effective care.

People told us the food was tasty and that they were supported to have enough to eat and drink. Care plans included information about their dietary needs and risks in relation to nutrition and hydration.

People told us they were supported by staff that were kind and caring and that they treated with dignity and respect.

Care plans contained the information needed to support staff to provide people's care in a manner that was responsive to their individual needs. People were supported to take part in a range of activities and make choices about how they spent their time.

People spoke positively about how well organised and managed the service was. There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take to address these concerns at the end of this report.

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.

Improvements were needed to ensure the proper and safe use of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect, but improvements were needed to ensure that the safeguarding and whistleblowing policies were up to date and reflected current legislation and local guidance.

Staffing levels were adequate to meet people's needs. Risks to people's health and wellbeing were assessed and systems were in place to manage these.

Is the service effective?

Good

The service was effective.

Staff sought people's consent before providing care and there was evidence that people's capacity to consent to their care and treatment was considered when their care plan was being developed. Improvements were planned which would clearly document how mental capacity assessment had been undertaken and what specific decisions had been reached in the person's best interests.

Staff received an induction and undertook training which helped them to deliver effective care. Further training was planned which would help to ensure that

People were being supported to maintain good health and had access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for by staff that were kind and caring and with whom they had developed good relationships.

People were treated with dignity and respect and their choices were respected.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs and wants. Staff showed they had a good knowledge and understanding of the people they were supporting and this helped to ensure that they were able to provide person centred care.

People took part in activities of their choice which they enjoyed and helped to reduce the risk of social isolation.

People and their families were asked to give their views and feedback about the care and support they received. Information on how to make a complaint was readily available within the service.

Is the service well-led?

Good

The service was well led.

The registered manager was a good leader, approachable and accessible to staff who valued her support and guidance.

There was an open and transparent culture within the service and the engagement and involvement of staff was encouraged and their feedback was used to drive improvements.

There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Farmhouse Care Home

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 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.

The inspection took place over two days on 20 and 23 May 2016. The inspection was unannounced.

The inspection team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. 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, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Some people were not able to speak with us and share their views about the care and support they received; however, we spent time observing interactions between people and the staff supporting them. We able to speak with five people who used the service and five relatives. We also spoke with the registered manager, the chef and five care workers. We reviewed the care records of three people in detail and the recruitment records for two staff. We also reviewed the Medicines Administration Record (MAR) for all 15 people. Other records relating the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection we received feedback from three health and social care professionals.

The last inspection of this service was in November 2013 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the Farmhouse Care Home and this was echoed by their relatives. One person said, "Yes I feel safe, I can't fault the care". A visitor told us, "Yes I am confident [their relative] is safe".

Suitable arrangements were in place for ordering medicines and relevant checks were made to ensure that these were supplied correctly. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. One person using the service was looking after and taking their medicines independently and relevant systems were in place to support this safely. We observed staff undertaking a medicines round. They assisted people with their medicines in a very person centred manner. The staff member explained to one person that their medicine was to help their bones. They stayed with people until they had taken their medicines, however, long this took. A healthcare professional told us, "Staff have a good understanding of the reason for particular medications and will bring any side effect problems to the attention of the GP".

However, some areas of how people's medicines were being managed required improvement. Medicines were stored within a locked trolley or within a designated medicines fridge. The temperature records for both the trolley and the medicines refrigerator were being recorded on a daily basis, but had a number of occasions been outside of recommended temperature ranges, but no action had been taken to rectify this. Medicines currently being stored in the fridge included insulin and it is important to store this and other medicines within recommended temperatures as it helps to ensure that they remain effective. We also found that the medicines fridge was not kept locked. The registered manager told us that they were shortly changing their pharmacy supplier and that a new medicines fridge was being provided as part of this arrangement. They told us the medicines audit would be amended to ensure that it effectively monitored whether areas used for storing medicines were being maintained within safe ranges. We noted that staff were not recording the date of opening on prescribed creams and lotions, again recording this information is important because if medicines have been opened for longer than recommended, they may not be safe to use or can lose some of all of their effectiveness.

We carried out a stock check of Controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The CD register did not tally with the medicines being stored in the CD safe. From reviewing medicines disposals records, we were able to see that the discrepancies were due to the CD register not being updated when medicines were returned to the pharmacy. Some people were prescribed 'as required' or PRN medicines to manage pain relief for example, however there were no personalised PRN protocols in place. Staff appeared to know people well, but PRN protocols would help to ensure that staff were able to provide a consistent response to people's individual signs of pain particularly important where people are living with dementia and may not be able to verbalise when they are in pain. The provider's medicines policy dated January 2013 was not robust and had not been updated in light of the guidance from the National Institute for Health and Care Excellence (NICE) Managing medicines in care homes which was published in March 2014. Training records showed that staff administering medicines did not have regular refresher training or an annual review of their competency to administer medicines safely. This was currently being

done every two years which is not in line with best practice guidance.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The proper and safe use of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. There was a 'Speak Out' poster displayed reminding staff and visitors about the types of abuse and contact numbers for reporting any concerns. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. One care worker said, "I would report any abuse….I want them to be treated like my mum". Each staff member we spoke with was confident the registered manager would take prompt action to address any concerns about a person's safety or any allegation of abuse. We noted however that the provider's 'Safeguarding Vulnerable Adults Policy' had not been reviewed or updated since 2010. It did not therefore make any reference to the Care Act 2014 which set out a clear legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect. This is an area for improvement. The provider's whistleblowing policy also needed to be reviewed and updated. The policy we were shown dated back to 2010. It did not make clear to staff the protections they have under the Public Interest Disclosure Act (PIDA) 1998 when raising concerns about the poor practice or abuse. However, staff we spoke with were confident that they could raise concerns with the registered manager who would take action. They were also aware of other organisations with which they could share concerns.

Assessments were undertaken to identify individual risks to people's wellbeing. For example, we saw that people had moving and handling risk assessments; falls risk assessments and a nutritional risk assessment. Where risks had been identified, measures were in place which helped to ensure that the risk was minimised. For example, one person who had been at high risk of falls had an infrared alarm in their room to alert staff that they mobilising so that they could check on the person and offer support as necessary. We saw that this person had also been referred to the physiotherapist and to the district nurse so that relevant health checks could be undertaken to rule out any medical cause for their increase in falls. We saw that where people were known to be at risk of poor nutrition, they had been placed on food and fluid charts so that their food intake could be monitored.

Where people were at risk of developing pressure ulcers or skin damage, skin care plans were place. Staff told us how they used body maps to record bruising or skin damage and would ensure that any concerns were shared and discussed at handover. We looked at the care plan of one person known to be at risk of developing skin damage and found a number of body maps which documented a variety of skin damage, It was not always clear that the cause of the bruising had been investigated. This is important to help prevent deterioration but any unexplained skin damage could indicate a safeguarding concern and might therefore require an alert to be raised with the local authority.

People told us there was sufficient staff to meet their needs. One person said, "They [care workers] are there in minutes when you need them, I can't fault them". A relative said, "There are plenty of staff, they all get attention". A healthcare professional told us, "The staffing levels are good and the manager and deputy manager always are on hand to discuss concerns both on the phone or when visiting". In addition to the registered manager, morning shifts were currently staffed by three care workers, one of whom was either a senior care worker or the deputy manager. Between 1.30pm and 4.30pm, staffing levels reduced to two care workers and then increased again to three staff until 8.30pm. During night shifts there were two care staff on duty. The registered manager told us these target staffing levels were based upon the needs of the people using the service and would be adjusted if necessary. They explained that a shift analysis form was used to note any issues or problems which had occurred. This analysis had previously indicated that a third staff member was needed between 4.30pm and 8.30pm to ensure that people's needs could be met safely and in

a responsive manner. This had been put in place.

We reviewed the staffing rotas for a four week period and found that the service had been staffed to target levels. Staff were also given lead roles on each shift such as encouraging with fluids and preparing the handover form. This helped to ensure that staff had clear roles and responsibilities. We were also able to see from the rotas that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them well. A number of ancillary staff were also employed including a chef and a housekeeper. The service did not employ staff specifically to oversee the laundry or to provide activities or entertainment and this remained the responsibility of the care staff. Care workers did not raise any concerns with us about staffing levels. They told us people's needs were met appropriately and that people were able to choose when to go to bed and when to get up and the staffing levels supported this. We observed that staff were able to provide support to people in a timely manner and were able to carry out their role and responsibilities effectively.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Good

Is the service effective?

Our findings

People told us they received effective care which met their needs. One person said, "The people here are well looked after, they [the care staff] know what they are doing". A relative told us "It's fantastic, a great little place, [their relative] is well looked after….they are always there to make sure they drink plenty…its very good five star". A social care professional told us how a person they supported was "Flourishing with the staff's care and support…staff are managing their anxieties really well". A health care professional told us they were really impressed with how staff had responded positively to their advice and were now proactive in identifying and managing skin care.

Care plans contained signed consent forms which recorded the person's agreement to have their photographs taken or for information about them to be shared with health and social care professionals. We observed that staff sought people's consent before providing care. For example, we heard staff say, "Can I just pop an apron on you" and "Can I give your tablets". The need to act in accordance with people's consent and choices was clearly referenced throughout their support plans. For example, staff were reminded to offer people a choice of clothing. A care worker told us, "We try to get [the person] to choose their outfit, or whether they want perfume on, we wouldn't just spray it on them".

There was evidence that people's capacity to consent to their care and treatment was considered when their care plan was being developed; although it was not clear that the steps taken to reach this judgement were in line with the principles of the MCA 2005. Where people had been deemed to lack capacity the assessment was not decision specific and did not follow the two stage test as set out in the MCA 2005 Code of practice. We saw examples, where relatives had signed consent forms, on behalf of a person who lacked capacity, without it being clear that they had the legal authority to do so. Where relatives do not hold a lasting power of attorney for health and welfare decisions about their care and treatment should be made following a mental capacity assessments and best interest's consultation. 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. The registered manager had plans to introduce a mental capacity toolkit developed by the local authority to help ensure that they and staff were able to fully document how the mental capacity assessment had been undertaken, what decisions had been reached in the person's best interests and who had been involved in this process. This process once embedded will help to ensure that the staff are fully implementing the principles of the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were waiting to be assessed by the local authority.

Farmhouse Care Home provided a comfortable and homely environment. It was clean and there were no malodours. However, some aspects of the home's décor would benefit from being updated. The main bathroom, whilst clean was dark and unwelcoming. Some of the carpets were worn. Many of the people living at the home were living with dementia, but the environment was not designed to be dementia friendly. Having a dementia friendly environment helps people to remain as independent and safe as possible and can include using contrasting colours and good signage to help people remain as independent as possible. The registered manager told us that the provider had engaged a consultant to review all of their care homes to improve their design and layout for people living with dementia, although it was not clear when this work would be undertaken at the Farmhouse Care Home.

New staff received a service based induction which involved learning about the values of the service, people's needs, key policies and the opportunity to shadow more experienced staff for period of time before they worked independently. Staff that were new to care were being supported to complete the Care Certificate. This was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. We did note that some new staff had not completed their induction programme within the timescales determined by the service. The registered manager told us this was in part due to their extended absence from the service earlier in the year but that plans were now in place to address this.

Staff felt the training provided was adequate and helped them to provide effective care. Staff completed a range of essential training which included topics such as moving and handling, safeguarding people from harm, infection control, health and safety, fire safety, first aid and food hygiene. We did note that only a small number of staff had completed training in caring for people living with dementia. Many of the people using the service were living with dementia and the service described itself as providing 'specialised dementia care'. One of the people living at the service could at times display behaviour which could challenge others, yet only three members of staff had training in this area. Since the inspection, the registered manager has informed us that she and other members of the senior team have been booked on a four day dementia management leadership course in June 2016. The remaining staff were booked on a one day course. We also noted that training was not currently provided on the MCA 2005. The registered manager explained that they had developed links with a local further education college to provide staff with additional training in areas relevant to the needs of people using the service such as end of life care. This will need to be embedded and sustained to ensure that staff continue to develop the skills and knowledge they need to meet people's needs.

Staff received supervision and an annual appraisal. Records showed that supervision was used to discuss matters relating to the needs of people using the service, but also the staff member's training needs, any areas for development, and what they were doing well. All of the staff we spoke with told us they received adequate supervision and found this a useful and supportive process. They also told us that the registered manager was always available to support and guide them in between formal sessions.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. People told us the food was tasty. One person said, "The food is good, you can say if you don't like something and they will get you something else. A relative said, "The food is good, its fish and chips today, there is always fresh vegetables".

There was a choice of two main meals at lunch time and pictures of these were displayed on a menu board in the dining room. On the first day of our inspection, people had scampi and chips or a chicken pie and mashed potato. When people first came to live at the home, they were asked for information about their dietary requirements and preferences. We spoke with the chef who was demonstrated a good knowledge of

these. Information was readily available in the kitchen about whether people liked large or small portions and whether they a diabetic diet for example. People's specialist diets were catered for. The chef used different coloured plates to highlight which meals were for those people living with diabetes and those that were for people who needed prompting or encouragement to eat. Staff were attentive throughout the lunch-time meal offering condiments and drinks and providing gentle encouragement. Plate guards were used to help some people continue to eat independently.

A selection of hot and colds drinks were available throughout the day and people were supported to maintain good hydration. A relative told us, "They are always asking if they want a drink". Another said, "They are always here to help [their relative] they make sure she drinks plenty". People's care plans contained information about their dietary needs including how best to support them with eating and drinking. For example, we saw that one person's eating and drinking plan explained how moving their head from side to side did not mean they did not want to eat, so staff were to continue to offer support. It was also noted that the person ate best when staff kept conversation to a minimum. Staff were aware which people needed encouragement to drink and provided this in a sensitive and person centred manner. People's weight was monitored regularly to assist in identifying whether they were at risk of malnutrition. Where people had lost weight this information was shared with the cook and if necessary food and fluid charts were completed. We did note that the fluid charts were not being totalled which can limit the effectiveness of these as a monitoring tool. The registered manager told us they would make immediate arrangements for the fluid chart to be revised to include a clear prompt for staff to total the amount taken each day by the person.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's support to ensure this was delivered effectively. People had regular visits from their GP and from other healthcare professionals such as community nurses, chiropodists and opticians. People's care records contained information about their medical history and clear records were maintained of the outcome of medical appointments and visits from the GP or the community nurse. A healthcare professional told us that staff "Communicate well with the GP practice and ask for visits appropriately…….care plans are discussed to guide management decisions and help manage unexpected situations". This helped to demonstrate that people were being supported to maintain good health and had access to healthcare services when needed. Staff had developed a 'Grab Pack' that was sent with the person in the event that they needed to be admitted to hospital. The pack contained key information about the person, including their medicines and family contacts. This helped to ensure that the transfer of care was managed in an effective manner.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind and caring. One person told us, "I couldn't be treated any better if I was royalty". Another said, "The staff here have been brilliant, they are amazing". A relative told us, "Everybody is very kind; [the care workers] are sweet and patient with [their relative]". Another relative told us the staff were "Kind, attentive, I can't fault them, the residents are all content". A healthcare professional told us, "If agitated or confused staff are compassionate and understanding and try to reassure anxieties the resident may have".

Our observations indicated that staff showed people kindness, patience and respect and offered people lots of praise and gentle encouragement. The staff team were cheerful and motivating, for example, at lunch time, one person was a little anxious, they apologised for being a nuisance. The care worker reassured the person and said, "You're not a nuisance at all, my children are a nuisance but not you". The person responded well to this and seemed a little more settled. Another person was noted by staff to not be eating their meal, they were encouraged, but when this was not successful, they were offered an alternative which they did begin to eat. Staff continued to be encouraging and supportive telling the person how well they were doing.

We saw a considerable number of warm and friendly exchanges between staff and people and the atmosphere in the communal areas was good natured and sociable and we heard a lot of laughter. People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work. Staff spoke fondly about the people they supported and it was clear that they had developed a meaningful relationship with each person and supported them in a kind and caring manner. One staff member told us, "[the residents] are all unique, I know them and they know me". Another staff member said, "I love it here, I love looking after the residents, I get great satisfaction…all the staff are kind and caring, [the registered manager] wouldn't have it any other way".

The registered manager and staff all showed a genuine interest in the people they supported and their relatives. Relatives and visitors were warmly welcomed and offered drinks and the opportunity of taking a meal with their relative. ". A relative said, "The food is lovely, for parties they put on beautiful buffets and make a birthday cake, they always involve family too, we would be welcome to share a meal". A social care professional who told us, [the registered manager] is fully supportive of family visiting whenever they wish to".

Staff spoke to us about how important it was to protect people's privacy and dignity and were able to give examples of how they maintained people's dignity through the way in which they supported people. For example, staff told us how they used the screens in the shared rooms for privacy and always knocked on people's doors before entering. We observed that this happened in practice. We also saw staff giving people privacy when using the bathroom and sensitively asking people who were sat in communal areas whether they would like to visit the toilet. A healthcare professional told us, "The staff have always treated my client with respect and dignity, often residents have limited understanding of instructions but the staff always talk clearly and explain what is expected of them, for example, when going to a bedroom for their GP to talk

quietly with them".

Good

Is the service responsive?

Our findings

People and their relatives told us they received care that was responsive to their needs and wants. A relative said, "If there is anything adverse the doctor is called in and they keep me informed". Another said, "One lady asked for a sherry at tea time, they sorted it". We observed that staff were attentive to people's needs and offered a prompt response when they needed assistance. For example, we heard a person say they were cold, a staff member immediately said, "Let me get you a cardigan". Staff responded quickly when a person began to walk without using their frame. Staff noticed when people were not eating or drinking well and offered encouragement.

People's needs were assessed before they moved into the home. This helped to ensure that staff had key information about the person and helped to ensure they could meet their needs. The registered manager involved the person and their relatives, if appropriate, in the assessment and planning care process. One relative said, "[The registered manager] spent a long time with us, finding out about [the person]". The care plans we viewed contained a 'social history' or 'my life story'. This helped to ensure that staff were provided with information about the person's life before they came to live at the home and were able to use this to engage with the person in a meaningful way. Care plans included specific, individual information, about the person's preferred name, their food likes and dislikes and their preferred routines such as how they liked their hair done, whether they liked to wear make-up and perfumes. Staff showed they had a good knowledge and understanding of the people they were supporting their knowledge of each person's preferences helped to ensure people received care and support which suited their needs.

People had key workers who worked closely with the person so that they became very familiar with their needs and wishes. Each month they produced a key worker report which reviewed how the person had been that month and whether there had been any changes in their health or wellbeing. The reports were then reviewed each month by the registered manager who used the information they contained to update people's care plans and risk assessments.

Staff maintained daily records which noted how the person had been, what they had eaten and what activities they had been involved in. A handover was held at each shift change which helped to ensure staff were kept up to date with people's changing health and welfare needs. When concerns were noted about a person's health or behaviour, there was evidence that staff had responded by making referrals to relevant healthcare professionals. For example, we saw that one person had been referred for a review by an occupational therapist. Staff had also contacted the GP due to one person showing signs of having a urine infection. This helped to ensure that people received treatment promptly. When a person developed an acute illness or an infection, an 'immediate' or short term care plan was put in place to guide the interventions of care workers and promote recovery. This all helped to ensure that staff had clear guidance about how they met people's needs.

People took part in activities of their choice which they enjoyed and helped to reduce the risk of social isolation. All of the people and relatives we spoke with were positive about the quality and quantity of the activities, a relative said, "They are always doing something, exercise, bingo, or singing every day, they also

have their hair and nails done". Whilst there was no designated activities staff, the care staff were able to spend time leading a variety of activities and a range of outside entertainers also visited the home. The activities available included, bingo, singing, skittles, nail painting, exercises and movie afternoons. Special events were celebrated and we saw that parties had been held on Halloween, St George's day and the Queen's birthday. The photographs suggested that people had enjoyed the celebration. A relative had fed back, 'Just a note to say how brilliant the Halloween party was….staff worked really hard and as always went above and beyond".

People and their families were asked to give their views and feedback about the care and support they received. The registered manager told us it was important to her that people really got involved in all aspects of the home and it was clear from minutes of meetings that their views were valued and acted upon. For example, we saw that at a recent resident's meeting, people had asked for lasagne to be added to the menu. This had been put in place. One person had asked for a bowl of fruit in their room. When we visited them we saw that this had been done. The meetings were used as a social occasion too and people enjoyed a glass of sherry whilst discussing menus and activities, The minutes recorded that people were asked whether there was anything they would change at the Farmhouse. One person had responded by saying, "I think it has everything just right". A relative had commented when asked what the service does well, "Listen carefully to my views and queries"

People knew who to speak with if they needed to make a complaint or raise a concern. Information about how to make a complaint was freely available within the service and within the service user guide. We did note that the service user guide needed to be reviewed and updated as it referred to out of date legislation Whilst no complaints had been made, the registered manager was able to describe how these would be documented, investigated, acted upon and used to improve the service.

Good

Is the service well-led?

Our findings

People and their relatives spoke very positively about how well organised and managed the service was. One person said, "I get on with [the registered manager], I can talk to them about anything". A relative said, "[The registered manager] is very good, you couldn't ask for a better manager, any problems you can go to her". Another said, "They are brilliant, they do so many things, even singing, they come round every morning and say hello". A health care professional told us, "I feel [the service] is very well led and managed…it's an excellent home". Our observations indicated that the registered manager had developed good relationships with each person. They spent a lot of time chatting with people and their visitors in a natural and relaxed manner. People responded well to them and seemed completely at ease with them. A staff member told us, "They [the registered manager] get involved, the residents all love her". Another said, the registered manager was "Very focused on the residents, really supportive, really professional".

There was an open and transparent culture within the service and the engagement and involvement of staff was encouraged and their feedback was used to drive improvements. Staff meetings were held on a regular basis during which staff were able to make suggestions about how to improve the service provided. A staff member said, "We can say, can we just try this? They [the registered manager] say, yes try it, they never dismiss anything". The meetings were also used to reinforce best practice. For example, staff were reminded of the need to body map any skin damage and include this in the daily report. Following the death of some people who had lived at the service for some time, the registered manager had used the team meeting to reflect upon the emotional and practical demands of caring for people reaching the end of their lives. The registered manager and staff reflected upon what they had learnt. The registered manager praised the staff team and shared with them positive feedback from the community nursing team about their care and attention they had provided. Staff told us this approach helped them to feel valued. They said that morale amongst the staff team was good. One staff member said, "I love it here… I don't feel I am coming to work".

During the inspection, we found that a number of the provider's policies needed to be updated and reviewed to ensure they reflected current legislation and best practice. The impact of this on people and staff was limited. This was because the registered manager was able to demonstrate that they had a good understanding of their role and responsibilities and this allowed them to be a good role model for the staff team and to promote the delivery of safe and responsive care. All of the staff we spoke with were confident they could approach the manager at any time about any matter. One staff member said, "I see them a lot, I can ask for advice, when she is on call I can ring her, she is always good on the phone".

There were some systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving safe and effective care and support. Staff had been given lead roles where they were responsible for completing a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. Weekly and monthly checks were undertaken of the environment. This included the fire safety arrangements, water temperatures and checks on equipment, such as wheelchairs and slings. These were mostly up to date and completed in line with the frequency determined by the provider. There was a fire box located by the front door which contained a 'Profile' for each resident which provided information about their abilities and the level of

assistance they would require for safe evacuation of their home. Information was readily available about emergency contacts for the gas and electric service providers and in the event of the home becoming uninhabitable, arrangements had been made to relocate people to a nearby centre where temporary accommodation could be provided. The registered manager advised us that a range of weekly and monthly tests to reduce the risk of legionella within the homes water system were taking place and an annual legionella risk assessment had been undertaken and had found no legionella present. We did note that the home had a stair lift which was used by people with mobility difficulties to access the first floor. However, a risk assessment had not been undertaken, to assess any potential risks to people from falling whilst using or accessing the stairs without support from staff. We spoke with the registered manager about this, who agreed to ensure this risk was assessed and planned for.

A range of audits had been undertaken and a monthly domestic / infection control audit reviewed the cleanliness of the environment. Action plans were produced as a result of these audits although we did note that the records did not always show that the actions required to rectify the issue had been resolved. The area manager undertook quarterly audits which reviewed a range of areas including, staffing, the food, and care plans.

The service had systems in place to report, investigate and learn from incidents and accidents. All accident forms were reviewed by the registered manager and logged on a safety cross to enable trends to be picked up and addressed so as to stop a similar incident happening again. A safety cross is a quality improvement tool which helps staff to quickly see at a glance the frequency of incidents such as falls or pressure ulcers. These can then be discussed and ideas or solutions developed to achieve improvements. Information obtained from a safety cross analysis had in part contributed to the registered manager arranging for a third member of staff to be rostered in the evenings to help keep people safe and enable staff to be responsive to their needs. This helped to ensure the service was constantly developing and improving.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Improvements were needed to ensure that medicines were always stored safely. Where people were prescribed 'as required' medicines, they did not have individualised protocols in place to guide staff as to when to give these. The provider did not have an up to date medicines policy and staff did not have an annual update of their skills and knowledge to administer medicines safely.