Nestlings Care Ltd

Higher Tunshill Farm

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service

Higher Tunshill Farm is a children's home providing treatment of disease disorder or injury to up to three children. The service provides support to children and young people aged between 10 and 18 years with their emotional and mental health. At the time of our inspection there were 2 children using the service.

Ofsted are the lead regulator for Higher Tunshill Farm as it is a children's home. The service is also registered with the Care Quality Commission for the regulated activity of treatment of disease, disorder or injury (TDDI).

People's experience of the service and what we found:

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

Children were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

CQC do not rate services that are defined as being a children's home and which are also registered with Ofsted.
Why we inspected

The inspection was prompted in part due to concerns CQC received about medicines. A decision was made for us to inspect and examine those risks.

We completed a targeted inspection to examine those risks and looked at parts of the key questions; Safe and Well Led.

We found medicines were stored safely within the home. Medicines were administered in a way that respected young people's preferences. However, improvements are required regarding the oversight of medicines optimisation and medicines incident reporting,

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

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Higher Tunshill Farm on our website at www.cqc.org.uk.
Enforcement [and Recommendations]

We have identified breaches in relation to:

HSCA 2008 (RA) Regulations 2014. Regulation 17 (2)(a) Good governance.

Please see the action we have told the provider to take at the end of this report.

We have made recommendations that the provider should;
•□improve the oversight of medicines processes

Follow Up

We will meet with the provider following this report being published to discuss how they will make changes to the services provided. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Inspected but not rated**
Is the service well-led? The service was not always well-led. Details of our findings are in the well-led section below.	**Inspected but not rated**

Higher Tunshill Farm

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. CQC do not provide a rating for the TDDI that is provided from this location.

Inspection team

The inspection team consisted of 1 CQC children's services inspector and 1 CQC medicines inspector.

Service and service type

Children's Home

Higher Tunshill Farm is a children's home where the children receive accommodation and care which is regulated by Ofsted. CQC regulate the treatment of disease, disorder or injury (TDDI) provided at Higher Tunshill Farm.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. There was an acting registered manager who had submitted an application to CQC.

Notice of inspection

The inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

During the inspection we spoke with children who lived at Woodhall House and their relatives. We also spoke to staff members, including managers as well as members of the senior leadership team, prescribing doctor, mental health nurse, commissioners and members of the external multi-disciplinary team. We observed a carer who was administering medicines. We reviewed a range of information both during and following the inspection. This included important information such as children's care records, risk assessments, policies and procedures and minutes of meetings.

The provider has a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Using medicines safely

People were supported to receive their medicines safely.
•Allergies were recorded for all children.
•There were no facilities for handwashing or cleaning equipment where administration and stock checks of medicines were taking place.
•Staff had received training in the safe administration of medication.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The failure to ensure robust governance for medicines optimisation was in breach of regulation 17(2)(a) HSCA RA Regulations 2014 Good Governance.
The provider recognised these issues at the time of the inspection and was working proactively to address them.

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

•□Inspectors spoke to children during the inspection and the children knew what medication they took and why and what the side effects were.
•□The provider used medication administration records (MAR) charts produced by the service to record the administration of medicines however the provider's policy was not always followed. For example, the policy states that only the doctor or the registered nurse can make changes to the MAR however we found unsigned entries which also did not contain the necessary information such as dose, frequency and strength. We also found some special warnings were missing from the MAR such as 'to be taken with food' or 'do not take any other products containing paracetamol'.
•□The medicine policy does not address the necessary cleaning procedure for equipment used in the handling of medicines.
•□Protocols were not always in place for medicines prescribed PRN (when required). It was unclear as to the procedures required to be followed before the administration of the medicine and the monitoring needed after administration. It was also unclear what effects that the medication may have on the child.
•□The roles and responsibilities of the doctor and the procedure for medicine reconciliation were not documented in the medicine policy.
•□There was no reference to temperature monitoring within the medicine policy to ensure medications are stored correctly. We found that the fridge minimum temperatures were regularly below 2 degrees Celsius, however there were no medicines stored in the fridge at the time of our inspection.
•□The procedures for administration of homely remedies was unclear. We found one person who had been administered ibuprofen as a homely remedy however ibuprofen was not noted on the homely remedy list provided to inspectors. For 2 children, their authorisation to administer homely remedies was out of date and had expired on 14 July 2023.
•□Higher Tunshill Farm had an acting registered manager at the time of the inspection. The acting registered manager had taken appropriate steps to apply for the registered manager position and was supported in that role by the senior leadership team.

Continuous learning and improving care

•□The policy stated that medicine audits must be completed by a mental health nurse and a registered

manager. However, other staff were completing the audits and errors had not been identified. This practice continued although it had been highlighted at the October 2023 internal medicines management committee report.

• Staff we spoke to told us that they felt well supported by the acting registered manager at Higher Tunshill Farm. Staff and children described a culture of respect at Higher Tunshill Farm. Staff felt that they could raise concerns with the acting registered manager and that this supported them in improving care for children. Inspectors examined evidence that staff had accessed mandatory training to support them in their roles.

• Most of the provider policies needed reviewing and were out of date according to their own timelines for review. The provider had plans to complete this.

Working in partnership with others

• Documentation relating to the delivery of TDDI was not always easy to locate because different parts children's records are stored in different places. The provider acknowledged this challenge and shared plans to move to a fully electronic record keeping system to address this issue. The current record keeping system made it difficult to understand how holistic care is being delivered.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure there were robust processes for medicines optimisation. Regulation 17 Person-Centred Care (2)(a)