Loomer Medical Limited

Farmhouse Residential Rest Home

Inspection report

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Tel: 01782566430

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 January 2017 and was unannounced. This was the provider's first inspection since registering the service with us. We found that some improvements had been made since the service had been registered with this provider, however further improvements were required. We found that the service was not consistently safe, effective, caring, responsive and well led. We found one breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the report.

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

Farmhouse Residential Rest Home provides accommodation and personal care for up to 23 people, some of whom may be living with dementia. There were 21 people using the service at the time of the inspection.

People's medicines were not always managed safely. Risks associated with people's mobility needs were not always managed safely and equipment had not been maintained to ensure it was safe.

People were safeguarded from harm as the staff and the registered manager knew what to do if they suspected someone had been abused. The local authority safeguarding procedures were followed when there had been an allegation of potential abuse.

People had a choice food and sufficient amounts to eat, however records relating to people's fluid intake were not always competed effectively to ensure that people had enough to drink. When people became unwell or their health needs changed they received health care support from other agencies such as GP's and district nurses.

Staff felt supported to fulfil their role and received relevant training to be effective. There were enough staff to meet people's needs, although staff we spoke with told us they needed more staff during the morning to meet people's needs in a timely manner. Not all people working at the home had been checked for their fitness of character to work with people who used the service.

The principles of the MCA 2005 were being followed as people who lacked the mental capacity to consent their care at the service were supported by their legal representatives to agree in their best interests.

Although most interactions between staff and people who used the service were respectful, there were occasions when people's emotional needs were not considered and acted upon. People had their own private room and their right to privacy was upheld.

People's preferences were not always recorded and respected, however the registered manager had a plan to gain the personal preferences of people to ensure staff were aware of people's likes and dislikes. There were a range of hobbies and activities available to people. There were trips and outings into the local community arranged. The environment was being adapted to support people living with dementia with signage and visual prompts to orientate people to time and place.

People and their relatives were encouraged to have a say in how the home was run through regular meetings. The provider had a complaints procedure and we saw informal and formal complaints had been acted upon.

There was an action plan to continue to improve the service and regular audits were completed. The registered manager and the provider had been responsive to our requirements and the local authorities concerns and had made improvements to the quality of the service being delivered.

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 consistently safe.

Risks of harm to people were not always minimised. Equipment to support people to move had not been serviced to ensure it was safe for use.

People's medicines were not managed safely.

There were sufficient staff to keep people safe, although not everyone working at the service had been checked for their fitness to work with people.

People were safeguarded from harm and abuse as the staff knew what to do if they suspected someone had been abused.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were offered a choice of food and drink however the provider could not be sure that some people were receiving sufficient fluids.

The principles of The MCA 2005 were being followed as people were consenting to their care or being supported to consent to their care when they lacked mental capacity.

Staff felt supported and received training to be able to be effective in their roles.

People received health care support when they became unwell or their health needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people's requests and emotional needs were not always acted upon.

People were offered choices and encouraged to have a say in how the home was run.

People's right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual preferences were not always known and acted upon.

There was a range of hobbies and activities for people to take part in. The service was being adapted to support people living with dementia to orientate to time and place.

There was a complaints procedure and people knew who to complain to if they needed to. People were being asked their opinion of the service they received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had been improvements to the service since the provider registered the service, however not all the systems in place to monitor and improve the service were effective.

There was a registered manager in post who worked with other agencies to improve the quality of care for people.

There was an on-going improvement plan which was discussed with people who used the service, their relatives and staff.

Farmhouse Residential Rest 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.

This inspection took place on 5 January 2017 and was unannounced. It was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at notifications the registered manager had sent us of significant incidents. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with six people who used the service and two relatives. We spoke with the registered manager and three members of care staff. We spoke with a health professional who provides support to people at the service.

We looked at the care records for four people who used the service. We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incidents, accidents and complaints records and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

Risk of harm to people had been assessed and we saw risk assessments had been put in place to minimise the risk. However, we saw one person had been unwell and their needs had changed in relation to their mobility. The staff had sought advice from a health professional who had advised them how to support the person to move safely with the use of a sling and hoist. However although the sling had been ordered it had not arrived at the time of the inspection. We observed that the person was not moved from the dining table for a period of at least four hours. We asked the registered manager why the person had not been supported to move from the table and they told us that because the equipment had not been delivered the staff were apprehensive about moving the person as we were present. There was no guidance available to support the staff to help the person move in the interim whilst they were waiting for the equipment. This left the person without their care needs being met for an unacceptable period of time and put them at risk of becoming sore and uncomfortable.

We looked to see if people's medicines were managed safely. Medicine was kept in a locked trolley in a locked medical room. Medicines were only administered by trained staff. However, we found that not all medication was accounted for. Medication kept in their prescribing boxes was not counted to ensure that the balance of medicine in the box coincided with the medicines that should have been administered. We found two people's medicines did not balance correctly as there were too many tablets compared to the amount that had been signed as administered. We found a tablet on the table in the dining room. The staff member responsible for administering the medicines did not know whose it was and why it was on the table. This meant that this person had not been observed to take their medicines and another person using the service could have picked the tablet up and taken it by mistake. This meant that people were at risk of not having their prescribed medicines due to the unsafe management of medicines.

We found that equipment used for the safe moving and handling of people had not been routinely maintained to ensure it was safe for use. Equipment should be annually serviced and we found that the service was overdue. This put people at risk of harm as the equipment being used to support people to move had not been checked as being safe.

The above issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we saw no delays in people receiving their care, the staff we spoke with told us that there were not enough staff to be able to support people safely during the morning. They told us that after 8.00am there were two care staff and a senior care staff available to meet people's individual needs. The senior carer was responsible for administering the medicines, so this would leave two carers to support people to get up, receive personal care and have breakfast. We saw one person required more support and supervision than staff were able to give them and they were at high risk of falls. Staff told us they had spoken to the operations manager about their concerns. We discussed this with the registered manager who informed us that staffing levels had been increased before 8.00am to help support people who wished to get up early as a few people had requested this. Other people got up at times that suited them. The registered manager

informed us that they had identified that they were unable to meet one person's needs due to insufficient staffing levels and this had been highlighted with the commissioners. The registered manager assured us that they would speak to staff about their concerns and look at the dependency tool they were using to ensure there were sufficient staff to meet people's needs throughout the whole day.

We looked at the way that new staff were recruited into the service and found that staff employed by the service had been checked for their fitness to work with people who used the service. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. However, we observed a contracted person at the service who we were told worked regularly at the service. This person had not had a DBS check prior to commencing work at the service. We discussed this with the registered manager who ensured that a DBS form was completed on the day of the inspection.

People were safeguarded from abuse as staff we spoke with knew what to do if they suspected someone had been abused. We saw that the registered manager had alerted the local safeguarding authority when one person who used the service had stated they didn't feel safe because of another person who used the service. They had also discussed some bruising which had been found on another person following a hospital admission. The registered manager demonstrated knowledge of the safeguarding procedures and followed them accordingly.

Requires Improvement

Is the service effective?

Our findings

People told us they liked the food and we saw that there were choices available that met their individual preferences. One person told us: "The food is ok, I get enough to eat there are choices of food". We observed that one person didn't like either choice for lunch so they were offered an alternative which they enjoyed. People's weight was monitored and action taken if they had lost weight. We saw one person had recently lost weight and had been prescribed a food supplement. We saw staff encouraged the person to drink the supplement and eat their meals throughout the day. However we saw one person required encouragement to drink sufficient amounts and another person was restricted from drinking too much. There were target amounts of fluid intake recorded on each person's care plan. We found that the fluid records for these people were not being completed regularly and checked on a daily basis to ensure that they had not had too much fluid or too little. This meant that the registered manager could not be sure that these people's fluid intake was appropriate for their assessed health care needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that the provider followed the principles of the MCA by ensuring that people when able to were consenting to their care and support at the service. When people were unable to consent to their care at the service due to their mental capacity to agree a referral for a Deprivation of Liberty Safeguards (DoLS) authorisation had been made to the local authority. The DoLS are part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

Staff we spoke with told us they felt supported and received training to be effective in their role. A member of staff told us: "I have had supervision with the manager and I'm doing my NVQ. We have staff meetings and we can speak to the manager any time she is approachable". There was an on-going training programme which we saw was monitored to ensure training was up to date and relevant to the needs of people who used the service.

People's health care needs were met when they became unwell or their needs changed. One person told us: "I see the doctor if I need to". We saw that referrals for support from health care agencies were made when people were experiencing changes in their health. For example, one person was receiving support from a community psychiatric nurse as they were becoming more anxious. Other people received care from the district nurses and occupational therapists and the GP regularly visited the service weekly or when people needed them. A health professional told us: "Things are a lot better under the new management; we visit twice a day for one person and have no concerns".

Requires Improvement

Is the service caring?

Our findings

A person who used the service told us: "So far, so good, the staff explain things to me and my room is ok". Another person said: "I can't remember how long I've lived here but I'm looked after well. I have a downstairs bedroom. I have enough to eat, I have plenty of drinks. Visitors can come when they want". A visitor told us: "It is brilliant here. The staff have made my friend a better person. They can't live on their own and look after themselves. I have seen improvements over about the last six months. There seems more interaction from the staff. The staff welcome me with a smile. I'm always made welcome, staff make me a hot drink. I think it's a good place".

We observed that interactions between staff and people were mostly kind and caring. We saw one person became upset as they missed their relatives. The registered manager reassured the person and went and fetched the photographs of their relatives to talk to them about and this immediately lifted their spirits. However, we saw incidences of when people's emotional needs were not always met. For example, we observed that one person sat through lunch with their head in their hands as if upset but no one interacted with them to ask them how they felt and another person was left sitting at the dining table for at least four hours with limited interaction.

At lunch time we observed that staff asked people if they would like to listen to some music and people agreed. We heard people singing happily whilst waiting for their lunch. However during lunch two people had the salt removed from them by a member of staff who had deemed they were applying too much. The staff member did not communicate with the people before taking the salt away and this also meant that other people sitting on the table would be unable to have any. This meant that people were not always communicated with in a respectful manner.

Several people complained of being cold in the lounge area and sat with blankets around them. One person told us: "I'm always cold". The inspection team found it was cold and asked a member of staff why it was cold. We were informed it was because bedroom windows were open along the corridor due to people's rooms being cleaned. We found several bedroom windows were open on a very cold day causing the lounge and corridor to be cold especially as most people were sitting and not mobilising independently. Consideration to the weather and people complaining of being cold had not prompted staff to act and action had not been taken to remedy this without our intervention.

Everybody had their own room where they were able to spend time alone if they wished to. The registered manager told us of plans to build an 'orangery' on the lounge to create more space for people to be able to sit away from others. The garden had been fenced to create a safe, private space for people to enjoy in the summer months.

There were regular meetings for people who used the service and their relatives to have a say in how the service was run. There were notice boards around the service with planned daily activities, menu choices and service up dates. The provider had begun to make changes to the environment to make it more homely by adding pictures, tablecloths and photographs of staff and people who used the service around the home.

Requires Improvement

Is the service responsive?

Our findings

People's individual needs were assessed prior to ensure that their needs could be met at the service. We saw people's care plans were reviewed on a monthly basis. However the assessments lacked people's personal information such as people's likes and dislikes and preferences. One person who had recently been admitted into the service told us: "There are some male carers. I prefer female carers. A male carer recently undressed me for bed I was embarrassed. I've never had the chance to say I prefer female carers". We discussed this with the registered manager who showed us they were in the process of implementing a person centred plan for each person which would ensure that all the staff knew people's individual preferences.

People were encouraged to be involved in hobbies and activities of their liking. The home had a designated activity coordinator who planned and arranged activities that people enjoyed. We saw that people were involved in a reminiscence session in the morning and there was a quiz planned for the afternoon; however people wanted to watch a film so this was facilitated instead. One person helped the domestic staff member with sweeping the floors. A member of staff told us: "[Person's name] likes to be kept busy and help out". Another person helped staff set the tables for lunch. They told us: "The staff are helping me set the tables". We were told that people were able to access the community on occasions. Two people had been Christmas shopping and out for lunch and there had been a coach trip to Blackpool. Everyone had been given the opportunity to go for a Christmas lunch in the local neighbourhood prior to Christmas; this was completed over several days, so everyone could attend.

The provider had made several improvements to the service since they had registered. We saw that environment was being adapted to meet the sensory needs of people living with dementia. We saw that they were following good practice guidance in relation to supporting people with dementia to orientate to time and place. Some of the toilets and bathrooms had been accessorised with block colours to signpost people to where they were. Signage and pictures were being added around the home to help people find their own rooms and other areas of the home.

There was a complaints procedure and people were encouraged to have their say through regular meetings. We saw that the registered manager acted on formal and informal complaints accordingly. The activity coordinator told us that they had recently had a meeting where they had discussed what had gone well over Christmas and what could be improved. There was a suggestion box and forms in the reception for people, their relatives and visitors to be able to complete with ideas for improvement.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who along with the provider had made improvements to the quality of the service since registering the service. The registered manager worked closely with partner agencies to improve the care being delivered. They had formulated an action plan and were working through it in consultation with people who used the service, their relatives and staff. However we found that further improvements were required to ensure that care being delivered was safe, caring and responsive to people's individual needs and preferences.

Several audits were being completed throughout the service, however not all had been effective. For example the medication audit had not identified that medication stock was not balancing and the maintenance audit had not identified that the equipment used to move people had not been maintained. Records in relation to fluid intake were not checked to ensure people were receiving sufficient to drink and care plans lacked personal information about people. This meant that the quality systems the provider had in place had not ensured that care being delivered was consistently safe and effective.

Staff told us that they liked and respected the registered manager and that she was approachable. One staff member told us: "The difference is if she (the registered manager) says she's going to do something she does it". However some staff told us that they had complained that there were not enough staff in the mornings but nothing had been done. We discussed this with the registered manager and provider who told us that initial improvements had been made to the staffing, however they would seek the views of the staff again to ascertain where their concerns lay.

Accidents and incidents were analysed and action taken to minimise the risks of the incident occurring again. We saw that incident reporting was thorough with an explanation of how the incident had happened and how it could be prevented.

The provider was investing in the environment by making improvements to the décor and maintenance of the service. There was a regular maintenance person who had a schedule of tasks and an improvement plan.

The registered manager and provider had been responsive to our concerns identified at the previous inspection when the service was registered under another provider. They worked with and responded to the local authority concerns and met with them to discuss the progress being made. There was a plan for continuous improvement which we saw was meeting the timescales that had been set.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care and support that was safe.