Mrs Yvonne Pointon

Roughcote Hall Farm

Inspection report

Roughcote Hall Lane
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Tel: 01782397440

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 21 March 2016 and was unannounced. At our previous inspection in 2013 we found no concerns in the areas we looked at. At this inspection we had concerns that people were not receiving care that was safe, insufficient staff numbers and ineffective governance systems. We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Roughcote Hall Farm provided accommodation and personal care for up to eight people with a learning disability. Eight people were using the service at the time of the inspection.

The service was not required to have a registered manager and was managed by the registered provider. For the purpose of this report we will refer to them as the 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 2008 and associated Regulations about how the service is run.

People were not safeguarded from abuse as the management did not report incidents of alleged abuse to the local safeguarding authority for further investigation.

Risks to people were not always minimised through the effective use of risk assessments and there were insufficient staff to keep people safe.

People's medicines were not stored and administered safely.

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 principles of the MCA were not followed to ensure that people were consenting or being supported to consent to their care and support. People were at risk of unlawful deprivation as referrals for a DoLS assessment had not been made for people who lacked capacity to consent to their care within the service.

Care was not always personalised and did not meet people's individual needs. Advice was not always sought from other professionals to ensure care being delivered was appropriate.

The systems the provider had in place to monitor the quality of the service were ineffective. Some staff training was out of date.

People had access to a range of hobbies and interests, however these were restricted to the day time hours due to lack of available staff.

Staff were kind and caring, however people were not encouraged to be as independent as they were able to be due to rules and routines.

People received health care when they were unwell and had sufficient to eat and drink to remain healthy.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risk of harm to people were not managed safely. People were not safeguarded from abuse as incidents of alleged abuse were not investigated. People's medicines were not administered or stored safely. There were insufficient staff to meet people's assessed needs.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the MCA were not followed to ensure that people consented to their care and support. People's nutritional needs were met, however they were not always able to access food and drink when they wanted to.

Staff were supported to fulfil their roles. People had access to health care professionals when they became unwell.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always treated with dignity and respect. People were not encouraged to be as independent as they were able to be.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive care that met their assessed needs and preferences.

There was a complaints procedure and people knew who to speak to if they had concerns.

Is the service well-led?

Requires Improvement

The service was not well led. The manager did not ensure there was sufficient staff to meet people's needs. Systems the manager had in place to monitor the service were ineffective.

People and staff liked the manager and found them approachable, however routines in place didn't support people

to make choices about their care and support.

Roughcote Hall Farm

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 was 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 21 March 2016 and was unannounced and was undertaken by two inspectors.

We reviewed information we held on the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports. These are notifications about serious incidents that the provider is required to send to us by law.

We spoke with five people who used the service, the manager, deputy manager and a care staff member.

We looked at three people's care records, medication administration records and staff rosters. We looked at the systems the provider had in place to monitor the quality of the service to see if they were effective.

Inadequate

Is the service safe?

Our findings

Risks of harm to people had been assessed and risk assessments had been implemented to minimise the risks to people. However some of the risk assessments required staff to restrict people to keep them and others safe. For example, taking people to their room when they were anxious and putting themselves and others at risk due to their behaviour. Professional advice and support had not been sought to support the staff to draw up behavioural plans to ensure people were kept safe during these times. The manager and staff had not received training in the management of challenging behaviour and the deputy manager told us: "It's the first time we have had people with challenging behaviour to this level". This meant that people were at risk due to inexperienced staff supporting them with their anxieties.

When incidents of alleged abuse had taken place these were not always referred to the local authority for further investigation. We saw records and the manager confirmed there had been incidents of abuse from one person who used the service to other people on several occasions. The manager and deputy manager did not recognise that these incidents were reportable. We saw one person had been recorded as being 'very distressed' by the incident. This meant that people who used the service were not always protected from abuse and the risk of abuse.

People's medicines were not stored and administered safely. We found that people's prescribed topical creams were all stored insecurely in a communal bathroom and some medicines were being stored in an unlocked fridge which people would be able to access. Other medication was kept in a locked filing cabinet in the kitchen. Neither the room nor fridge where the medicines were kept, were temperature checked to ensure that the medicine being stored in them was being maintained at the correct temperature. This meant that the staff could not be sure that the medicine was safe for use. We checked one person's medicine and saw that the directions on the medication administration record (MAR) did not reflect what was on the prescribing label on the medicine. Records confirmed that this person had an increase in their medication but they were not being administered the correct amount as recorded on the MAR. This meant that this person was not having the correct dose of prescribed medicine and left them at risk. The medicine had been prescribed to help them when they became anxious. We saw that it had been recently administered however the person's records did not state a clear justification for the administration of the medicine. This meant the manager could not be sure that this person was having this medicine at the required times.

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

There were not enough staff to keep people safe. One person required one to one staff support at all times during the day due to their unpredictable behaviours. We looked at the rotas and saw it was recorded that there were times every evening when this person did not have their one to one support. At these times we saw there was only one member of care staff and the manager. The manager told us they spent their time in the office which was in the grounds of the service. The manager was unable to tell us why the person's one to one hours were not available at these times. This meant there was only one staff available to the eight people who used the service and the person's allocated one to one was not available. Some people used

mobility aids and one person was at high risk of falls and there would be times they would be left unsupervised. This put the person, the staff and other people who used the service at risk.

This was a breach of Regulation 18 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

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. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 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. People who used the service lacked capacity to consent to their care at the service due to their learning disabilities and were under constant supervision and control. No one was able to leave the service unsupervised. The manager told us they knew about DoLS but had not referred people to the DoLS team as they had not recognised that people may be being unlawfully restricted of their liberty.

We saw one person's care plan for supporting them when they were anxious and exhibiting challenging behaviour. The care plan stated that the person should not be allowed to access the community if they behaved in an unpredictable manner. The care plan stated that the person understood the consequences of their actions. A mental capacity assessment had not been completed to ensure that the person did understand consequences to actions and that this was a lawful restriction of their liberty. This meant that the principles of the MCA and DoLS were not being followed.

This was a breach of Regulation 13 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People were unable to help themselves to food and drink and had to wait for staff to serve them at allocated times of the day. One person told us: "I can't make a drink and I have to ask for a sandwich". This meant that people who were hungry or thirsty were unable to access food and drink when they needed it. The manager told us people could have food and drink if they asked for it. People were encouraged to choose what they liked to eat and this was discussed in regular meetings. One person told us: "The food is really nice, we get a choice of what we have, and we can have something else if we don't want what's on the menu. We also go to the pub for lunch as well".

People we spoke with told us they liked the staff and that they were kind to them. One person told us: "The staff are very good to us, they make sure we are okay". A staff member told us that they felt supported and there was an on-going programme of training. Regular staff meetings and supervision of staff was undertaken by the manager.

People were supported to attend health care appointments with professionals such as their GP, opticians and community nurses. We saw a visiting health professional on the day of the inspection. One person told us how staff had supported them to see their GP when they had felt poorly. The person said: "Sometimes I get pain and staff will get my pain killers or phone the GP if I'm not very well".

Requires Improvement

Is the service caring?

Our findings

People were not always encouraged to be as independent as they were able to be and there were rules and restrictions which did not support people in making their own choices. We saw records and two people confirmed that most people were dressed in their night wear at 6.30pm every evening. This time coincided with the time that the staffing levels decreased. Two people told us they had to be in their bedrooms by 9pm. The manager confirmed that they felt that people needed adequate rest so encouraged people to go to their rooms at this time. They told us people could watch TV in their bedrooms if they wanted to.

People told us they couldn't help themselves to snacks or drinks when they wanted to. Several people would have been able to do this with limited help and support. One person had a pet they kept in the garden. We saw records that an incident had occurred where the person had wanted to go to see their pet but the manager and staff had stopped them because it was slippy due to bad weather. Records of the incidents showed that the person had been upset by this and had shouted at the manager. The person had been told to go to their room to calm down. This did not demonstrate that the incident had been dealt with in a respectful manner.

There were areas of the service that people were discouraged from entering unsupervised. The managers own kitchen was in the middle of the service and people had to pass through it to get to the kitchen where they had their meals. People were not encouraged to go through the kitchen on their own and mainly stayed in the sun lounge area unless supported through by staff. This meant that people were not free to independently come and go within their own home.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the staff and felt cared for. One person told us: "I can always talk to the staff about any problems and they will sort them". Another person told us: "We have a laugh me and the staff". From our observations the manager and staff were caring in their approach to people.

Everyone had their own private bedroom and bathroom which they spent private time in if they wanted to.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was personalised and met their individual needs. There were routines in place which restricted people from receiving personalised care. One person's pre admission assessment stated that they should be encouraged to be as independent as they were able to be, with household tasks and basic cooking skills. The assessment had been completed with the support of an occupational therapist who had advised that this person was given opportunities to work towards independence. We saw that the person was not being encouraged to be independent and was following the routines of other people who used the service.

People were offered day time opportunities and activities. Everyone went out most days to a variety of places including college, shopping and meals out. One person told us:" I'm always busy doing something, I went to Alton Towers for my birthday". Another person told us how staff supported them to go to church every Sunday. They told us:" I love church I go every Sunday". However people were unable to go out in the evening for evening activities due to the lack of staff. The manager told us that there had been a change in the needs of the people who used the service over the last couple of years and they now cared for younger people. The manager recognised that some people's social and emotional needs may not be being met as they should, they told us they would speak to the local authority to assess people's needs and ensure there was adequate funding to care for people.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were clear and comprehensive and regularly reviewed. Staff knew people well and knew what was in people's care plans, however they did not always follow the recommendations made by other professionals. For example, one person's care plan stated they should be encouraged to be independent and this was not happening. We saw other examples of care plans being followed by staff. Records showed that one person often became upset when they returned from visiting their relatives. The manager and staff demonstrated they knew this and told us how they supported this person at these times.

People told us they would speak to the staff or the manager if they had any complaints. One person told us: "I can talk to staff about any problems and they sort them, and we have the residents meetings." Another person told us: "I talk to my relatives or the staff". There was a complaints procedure and the manager told us that there had been no new formal complaints.

Requires Improvement

Is the service well-led?

Our findings

The manager did not always follow the correct procedures in relation to their registration of the management of a care home. They were not following the safeguarding procedures by reporting alleged abuse and the principles of the MCA were not being adhered to ensure people were not being unlawfully restricted of their liberty.

One person was not receiving the staffing hours they required and this put them and other people at risk of harm. The manager was not able to offer an explanation as to why the staff hours were not available during these times. It was unclear from this person's records when there had been an incident which had required extra support from staff due to their unpredictable behaviour. This meant that incidents were not being monitored so the risks to the person and others could be minimised. Professional advice and support had not been sought to ensure that this person's needs were being met safely.

The medication audit had not identified issues with medicines and this left people at risk of receiving medicine that was not prescribed for them or that was not safe for use. The manager told us that the medication management had been delegated to a member of staff but this had not been overseen or checked by the manager or deputy manager.

The manager had routines and restrictions within the service which did not promote people's independence. People's assessed needs were not being met as professional advice was not always followed, for example one person had been assessed as being able to work towards independence, however they were not being given the opportunity to do this. One person would have benefited from specialist support in relation to the management of their challenging behaviour but this had not been sourced.

The manager told us that people did not receive enough benefits to be able to go out in the evenings or have a holiday, they had not approached the local authority to request a reassessment of people's needs to ensure they were able to live a full and varied lifestyle.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were relaxed and chatty with the manager. One person told us: "You can always talk to [manager's name]; she's really nice and always asks if you are okay". Staff told us they felt supported by the manager, they told us: "If you've ever got a problem [manager's name] will sort it out".

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving care that was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The principles of the MCA were not being followed to ensure people were not being unlawfully restricted of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor the quality of the service were ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to keep people safe.