Farmhouse Care Limited

Farmhouse Residential Rest Home

Inspection report

Talke Road
Red Street
Newcastle-Under-lyme
Staffordshire
ST5 7AH
Tel: 01782566430
Website: pargan_2000@yahoo.com

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 29 April 2015 and was unannounced.

Farmhouse Residential Rest Home, provides personal care and accommodation for up to 23 older people, who may have dementia.

A manager was in post but they were not registered. 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.

Summary of findings

People's risks were assessed in a way that kept them safe from the risk of harm. Where possible people's right to be as independent as possible was respected.

People who used the service did not always receive their medicines safely because, on occasions, there was an inadequate stock of medication.

We found that there were not always enough suitably qualified staff available to meet people's needs in a timely way. Sometimes people were waiting a long time for assistance.

Staff were trained to carry out their role and the provider had plans in place for updates and refresher training. The provider had safe recruitment procedures that ensured people were supported by suitable staff.

Staff had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Staff knew how to support people in a way that was in their best interests and advice had been sought from other agencies to ensure formal authorisations were in place where people may be restricted.

People were supported to maintain good health and were referred to relevant health care professionals as and when required. People had enough to eat and drink and were supported with their nutritional needs.

People were treated with dignity and respect. Most staff were kind and caring but, on one occasion, a staff member spoke abruptly to a person.

People did not have opportunities to be involved in hobbies and interests and their was no entertainments programme in the home.

The provider had a complaints procedure available for people who used the service and complaints were appropriately managed.

There was a positive atmosphere within the home and staff told us that the registered manager was approachable and led the team well. Staff received supervision and had opportunities to meet regularly as a team.

The provider had introduced a system to monitor the quality of service provision. The system was in it's infancy and needed to develop in order to show how effective this would be.

Summary of findings

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 not consistently safe.

People were sometimes exposed to risks from their environment.

There was not always enough staff provided to ensure people were safe.

Medicines were not always managed appropriately

Individual risk assessments were in place that helped to ensure people were kept safe.

Staff were recruited properly and staff knew how to meet people's needs and raise concerns about abuse and/or poor practice.

Requires Improvement

Is the service effective?
The service was consistently effective.

Staff were given training and had the skills to meet the needs of those in their care.

People's consent was obtained before staff supported them.

People requiring assistance at mealtimes were supported to have sufficient amounts of food and drink, and their health care needs were being met.

Good

Is the service caring?
The service was not consistently caring.

Most staff showed care and compassion towards people but sometimes staff spoke to people abruptly.

Personal care was carried out with privacy and dignity and staff.

People were involved in making decisions about their care on a daily basis and their privacy was respected.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Staff did not always respond to people's needs in a timely way.

People were not routinely supported to follow their hobbies and interests.

People were able to raise concerns and express their views and opinions. However, people could not always be confident that action would be taken to address concerns.

Requires Improvement

Is the service well-led?
The service was not consistently well led

Requires Improvement

Summary of findings

There was a manager in post but they were not registered. The provider was aware of their responsibilities to provide a registered manager.

Staff were now more motivated and supported to question practice.

The provider monitored the quality of services but did not always show what action had been taken to bring about improvements to care.

The quality monitoring system was in its infancy and yet to be fully developed.

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.

The inspection took place on 29 April 2015 and was unannounced.

The inspection team consisted of two inspectors.

At our previous inspection on 9 October 2014 we found that the care and support people received at the home was inadequate in four out of the five domains we inspected. We told the provider that they must make improvements in all five domains in order to improve the quality of services provided to people. Following this inspection the provider had employed a management consultant to help bring about improvements. They produced an action plan and kept us regularly updated of the improvements they were making.

The provider had kept us updated of events by sending us relevant notifications. Notifications are reports of accidents, incidents and deaths of service users. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority, commissioners and Healthwatch Staffordshire.

We spoke with seven people who used the service and three relatives. We spoke with the manager of the home and four members of care staff, including a senior care staff member.

We observed the care and support people received in the home. This included looking in detail at the care and support three people received, and if it matched the planned care we saw in their records. This is called case tracking. We also looked at these people's daily care records and records of their medication. We spoke with staff about how they met the needs of these people and others.

We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

People who used the service did not always receive their medicines according to their prescription. We saw for one person they had missed three doses of a medicine because the home had run out of stock. The manager said that they had spoken with the GP in respect of the person missing their medicine and were waiting for a delivery of this. We observed a senior care staff member administering medicines according to each person's needs. The medication round was completed in a timely way, ensuring that people who used the service received their medicines as they were prescribed. We were told that only senior staff who had received suitable training administered medication to people and that competency checks were carried out by the manager. This ensured that staff were competent to meet peoples' needs relating to medicines. There were procedures in place and information for staff to help ensure that medication was handled, stored, administered and disposed of safely.

We saw that there were not always enough staff around to respond to people's needs in a timely way. For example we observed a person calling out to be taken to the toilet for twenty minutes. A staff member came into the lounge and told the person that there was no one to help her to the toilet and that she would have to wait. The person told us, "I will have to do it in my pad. Sometimes I wait half an hour for help." We saw that the lounge area was unsupervised whilst staff were busy duting the morning. The provider said that would be reviewing staff provision at the home.

People who used the service and relatives thought that the provider had made some improvements and that their relatives received safer care now. A visitor told us, "Things have changed for the good since the new manager was appointed. Prior to that there were many things I was not happy about, but I can go home now and not worry about what happens when I am not here. I feel that [person's name] is quite safe now." We asked a person recently admitted to the home if they felt safe, they told us, "I do feel safe here, staff are always there to help us." We saw that people were kept safe and that staff monitored people's whereabouts. However we observed that the door to the store room containing cleaning substances was left open. The cupboard inside was also unlocked. We saw people who had dementia care needs walking freely around the home who could have been able to access the cleaning products. The manager told us that this door was usually locked.

People who used the service had undergone an assessment of their needs relating to health and safety. Risk assessments were in place to help keep people safe. For example, we saw that one person had a tendency to push themselves back on a dining chair, potentially harming themselves, other people, visitors and staff. The provider had assessed the risk of harm and acted upon this to reduce any potential risk. The risk assessment stated "Use the upper part of the dining room to give more space and allow room to manoeuvre". We saw that staff followed these instructions whilst supporting this person in the lounge. Risk assessments had all been reviewed monthly to ensure they remained effective. We saw where a hoist had been purchased for another person to help reduce the risk of them falling.

At our previous inspection we saw that people had sustained repeated falls. At this inspection we observed staff helping people to walk around the home safely. Where people were unable to mobilise we saw staff transfer them safely using appropriate equipment. We observed two staff members transfer a person using a hoist from a wheelchair to a chair. Staff told us, and we saw from records, that staff had received training in how to move and handle people safely. The number of falls people were now sustaining in the home had reduced since our last inspection. Falls risk assessments had been reviewed following falls. The manager told us that the occupational therapist had visited regularly. She said, "They have been very helpful, for instance in de-cluttering bedrooms where people had previously fallen and making bedrooms safer."

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We saw that people who used the service were protected from harm by the recruitment procedure adopted by the provider. Staff were carefully selected to work at the home and were only offered employment following suitable references and relevant checks. This ensured that staff were safe to work with people who used the service.

People were protected from harm because staff had been trained in how to recognise and report poor practice or

Requires Improvement

Is the service safe?

abuse. Staff told us that they knew about the procedures in place and had received training in this. The manager was also fully aware of her roles and responsibilities in identifying possible abuse and making referrals.

Good

Is the service effective?

Our findings

At our previous inspection we found that not all staff were trained to meet the needs of people who used the service. Since then the provider had implemented a staff training programme to ensure that staff were equipped with the knowledge and skills required. People who used the service and their relatives told us that staff knew how to look after them. One relative said, "I was worried about the care of [person's name] before because the care they received was poor. Since October the care has really improved here. Staff know what [person's name] needs and they are cared for much better now."

Staff told us, and we saw that staff understood the needs of people. For example a staff member explained to us why a person reacted in a certain way and what could trigger certain behaviours. We saw the staff member helping the person to stay calm. Staff told us that they had received training in how to meet the needs of people who used the service. This included training in meeting the needs of people with dementia. Records of staff training showed that not all staff had received the training they required. The manager told us that staff training was, "a work in progress."

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves. We saw that mental capacity assessments had been completed where there was doubt about people's ability to make decisions. Where people were not able to make their own day to day decisions such as what to wear, eat or do. These decisions could be made by staff but still involving the person in making the decision as far as they were able to. More complex decisions were made by arranging a best interest's decision meeting, involving the person, relatives, other professionals and care staff. We saw examples of best interests decisions made in relation to two people wanting to leave the building. Mental capacity assessments were reviewed monthly as part of the person's care plan.

The provider recognised that some people were being restricted in the home and had made applications for DoLS where people were closely monitored or supervised that may have implications for their liberty. We saw that two DoLS authorisations had been made by the Local Authority relating to people who may wish to leave the building. Staff we spoke with were aware of the needs of these people and why a DoLS authorisation had been made. A staff member said, "I know that it's because [person's name] keeps trying the door to get out.

The provider sought people's consent to care and treatment and enabled people to access advocacy services. For example a record we saw showed that a person had signed their care plan, giving consent to care and treatment and the person understood why and what they had signed for. The person had no active relatives but had an advocate to advise and assist with any decision making.

We saw that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made by people able to do so, but usually involving family members. This is a legal order which tells a medical team not to perform CPR on a person. Where the person was unable to make a decision about this, following a mental capacity assessment, their family had been involved in the decision making. In two care records we found authorisations had been signed by the GP for DNACPR decisions. The GP had recorded that relatives had been involved in the decision making process. The manager told us that relatives were always involved in these decisions. We saw that DNACPR decisions were reviewed annually or more regularly by the GP to ensure they were still relevant.

At our previous inspection we found that people did not always have enough to drink. Since then the provider had introduced improvements to how people are supported to eat and drink. Nutritional assessments were in place for each person with related risk assessments and weight monitoring. We saw that where there were concerns about weight loss referrals had been made to the GP. We saw staff helping and encouraging people with their meals and drinks. Records confirmed that people's nutritional intake was monitored. People enjoyed the meals served at the home. One person said, "The food is brilliant". We saw the midday meal served which looked appetising and nutritious. People were offered a choice of main and desert. Afterwards people told us they had enjoyed the meal. We saw people being offered drinks and snacks

Good

Is the service effective?

throughout the day. A person told us, “They bring up a cup of tea when I wake at six in the morning.” We saw from fluid records that people had been offered drinks when awake at night.

At the previous inspection we found that the provider had not always made appropriate referrals to health care professionals. Since then the provider had introduced improvements to the health care provision for people. People who used the service benefitted from good health care because staff made timely and appropriate referrals for people to be seen by relevant professionals. Staff monitored people’s health care needs and acted when people’s needs and conditions changed.

Referrals to health professionals were made following assessments. For example, for one person a continence assessment had been followed up by referrals, assessment and advice from the continence nurse specialist. The person wanted to maintain continence but needed specialist advice. We saw the person had been seen by the continence nurse on several occasions since then. We saw that people‘s risk of developing pressure ulcers was assessed and preventative measures put in place to lower the risk of skin damage. We saw that a person who needed, ‘to use a pressure relieving cushion at all times’ was sitting on a pressure relieving cushion throughout the day. There were close links with the GP and district nurses. We saw a district nurse visiting who had come to administer insulin to a person.

Requires Improvement

Is the service caring?

Our findings

People were not always addressed in a kind and caring manner by staff. We observed one staff member speaking abruptly to a person who asked to use the toilet. The staff member said, "I can't help you, [staff member's name] will come to you as soon as they come out. They are dealing with [person's name]." People who used the service had mixed feelings about how they were treated by staff. One person said, "A lot of the staff are very good and talk kindly to you but not all of them are like that." Another person said, "Some staff are better than others." We saw that, with the one exception, staff spoke kindly and respectfully to people.

We saw that people's families were involved in supporting their relative in the home. For example two visitors were assisting their relatives to eat and drink. Another visitor had taken their relative out for most of the day and told us that they did this often.

We saw that staff were thoughtful about people's needs. For example we saw that staff had prepared a bath for a person and had brought in their clothes to keep warm on the radiator. A staff member said, "Oh yes we always do that so that the clothes are nice and warm when [person's name] puts them on. Later in the day we spoke with the person and their visitor who told us, "Staff are very helpful and considerate that is the sort of thoughtful thing they do."

Staff members were able to give us examples of how people's privacy and dignity were respected. A staff member explained how they [the staff] promoted privacy and dignity whilst supporting people with personal care. They also told us that daily care records did not have names recorded on them but initials and room numbers to ensure confidentially. We noted that staff carried out personal care for people within the privacy of their own bedroom or bathroom.

People's families were made to feel welcome by staff at any time. A person told us "It is great here, I would come again. The staff are marvellous and can't do enough. I will recommend this home to friends." A visitor told us, "It is smashing here. Staff are rushed off their feet sometimes but they are excellent. Last week we were all out on the lawn having tea and biscuits. They also brought ice cream and lollies. We were all having a laugh. You are made very welcome."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we saw that people were not supported to maintain their hobbies and interests. We saw that there had been little improvement in this area. People's social history had been obtained but there were no structured plans in place to meet people's individual social needs. A few people went on trips out with their families but most never left the home. People were sat in their chairs with very little stimulation apart from when staff spoke with them. When asked what they thought of the activities in the home a relative had commented in a survey, "What activities? What entertainment?"

We observed that, at times, staff did not respond to people's needs and give care and support when it was needed. One person was waiting and calling out for personal care for twenty minutes and told us that they sometimes had to wait for up to 30 minutes for help.

When we carried out the last inspection we found that care was not based around meeting people's individual needs. Since then the provider had made improvements to how people received their care. Care and support was now more focussed on the person as an individual. For example, a relative explained to us how the care and support their relative received had improved. They told us, "Proper personal care for [person's name] is now in place." We saw that staff were aware of how people preferred their care delivered. A staff member said, "People get up and go to bed when they want to and the same with bathing preferences." New care plans had been developed which supported staff to deliver care according to people's individual needs.

People and/or their relatives had been involved in compiling care information to improve the service provided for people. All relatives had been asked by the provider to complete a social history for their relatives. The ones we saw were detailed and informative. A staff member said, "This is a really good idea as we can see what the person was interested in and what they were like before they came into the home. It gives us something to talk with them about and to share fond memories with them."

Relatives confirmed they were kept informed of any changes affecting their relatives and their views were sought. A relative told us, "They ring me up if there are any changes with [person's name]. They are good like that." We saw letters inviting all relatives to two separate relatives' meetings. The meetings sought to discuss the changes being made and future changes to the service. The manager told us that relative's views were crucial to making progress and involving people.

At our last inspection people who used the service and their families thought that their concerns were not taken seriously and/or acted upon. The provider had made some improvements in this area. People had mixed feelings about this. Some people felt that they could go and speak with the manager and that their concerns would be addressed. A relative told us, "Things have changed for the good since the new manager was appointed." On some surveys recently completed, relatives had commented that they did not always receive feedback to the concerns they had raised.

Requires Improvement

Is the service well-led?

Our findings

The current manager had been in post since October 2014 but had not yet applied to become Registered Manager at the home. This meant that there was no manager in post who was legally responsible for meeting the requirements under the Health and Social care Act 2008 and associated Regulations about how the service is run. The provider was aware of the need to apply for registration for their manager and told us that this would be addressing this in the near future.

At our last inspection we found that the service was not well-led and people who used the service had not benefitted from good quality care. Following that inspection the provider had employed a management consultant to help bring about the required improvements. Since then the current manager had worked alongside the management consultant to introduce these improvements. There was an action plan in place to help improve standards of care people received. The provider had kept us regularly informed of the improvements they had made. People who used the service and their relatives had been involved in the changes and told us that improvements had taken place. A relative told us, "Since October last year things have changed. I can't find fault with the manager she is on the ball. The place has vastly improved in fact unbelievably so. I can go home now and not worry about what may be happening here. The manager has really turned the place around."

Staff who worked at the home were now more supported to carry out their role. Staff training had been implemented and staff received regular supervision. A staff member said, "I feel supported and think the manager here is really good." Another staff member said, "I have just had my appraisal, I think [staff member's name] is great."

There was now more of an open positive culture at the home where staff and people were able to raise suggestions for improvements. Meetings had taken place where staff and relatives could air their views and be kept up to date with the changes taking place at the home. Staff felt able to talk to the manager and raise concerns about poor practice in line with the Whistleblowing policy. A staff member told us, "I would go straight to the manager if I saw something which I thought was abuse."

The provider had introduced a quality monitoring system but did not always respond by taking action. We saw that people's views and suggestions had been obtained but action had not routinely been implemented to bring about improvements. For example, on a survey a relative had written, "My relative prefers hot drinks to cold, these are not always given." We could not see what action had been introduced in relation to this. Other comments were, "Staff listen but no feedback" and "You do not get feedback if you raise a query."

The provider had introduced quality audits to ensure that people were kept safe. These included audits of accidents and incidents, infection control audits and health and safety checks. The provider ensured that fire safety checks were carried out as required and that all equipment used was properly maintained and serviced. Quality monitoring was in it's infancy at the home and we will need to look at this on our next inspection to see how this has developed.