Mrs H Burnett-Price

# West Farm House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We carried out this inspection over three days on 14 and 16 June and 4 July 2016. The first day of the inspection was unannounced. There was a delay until the inspection was completed due to the availability of the provider.

The last inspection to the service was on 16 September 2014. The provider had satisfied the legal requirements in all of the areas we looked at.

West Farm House is registered to provide accommodation and personal care for up to 10 people. During the inspection, there were 9 people living at the home.

A registered manager was not required due to the registration of the service. 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. The provider was responsible for the day to day management of the home. They were not available on the first two days of the inspection due to being on holiday but were present during the whole of the third day.

Quality auditing systems were not effective as shortfalls in the service were not being sufficiently identified. A monthly audit was undertaken but this did not cover specific areas, such as infection control, medicine administration or the environment. Not all management systems such as recruitment were being properly managed.

Potential risks to people's safety were not being identified and properly addressed. The hot water was of an excessively high temperature, which increased the risk of scalding. Radiators in corridors and communal areas were not covered and there was a hot pipe in the downstairs toilet. These issues increased the risk of people burning themselves if they touched or fell against the hot surfaces. Some fire doors were propped open and not all doors closed properly, when the fire alarm was activated. These issues meant fire and smoke would not have been properly contained, in an emergency. The fire panel was not clearly marked and staff were not aware of the different areas of the home, identified as zones. This lack of knowledge increased the risk of delay, when trying to locate and manage a fire.

Whilst there were enough staff on duty to assist people effectively during the day, people were not properly supported at night. A member of staff undertook a "sleeping in" role but there were no waking night staff. This impacted on people's safety and did not ensure those people with night time care needs, were appropriately supported. The lack of waking night staff compromised some people's dignity. Staff were not always responsive to people's changing health care needs particularly in terms of skin integrity and mobility. Each person had a plan of their care but the information was insufficiently detailed and did not identify individual needs or the support required.

People's medicines were not being safely managed. The medicine administration records were handwritten, which increased the risk of error. Staff had not consistently signed the records to show they had given people their medicines as prescribed. Instructions for topical creams and medicines to be taken "as required" were not clear. This did not ensure staff had sufficient information to administer or apply the medicines as prescribed, for maximum effectiveness.

Good infection control was not being followed. The laundry appliances were located in an outbuilding, which meant the walls and floor could not be wiped hygienically clean. Systems were not in place to reduce the handling of soiled items and such items were inappropriately soaked, before being placed into the washing machine. This increased the risk of contamination.

Staff undertook a range of up to date training to help them do their job more effectively. However, not all topics related to older age or people's changing needs. Staff had undertaken training in moving people safely but this had not included practicing their learning. Staff were receiving support from health care professionals to address this.

People were supported by a small team of staff who knew them well. Staff felt valued and well supported. They met with the provider on a formal basis to discuss their performance and any concerns they might have. The provider had a "hands on" approach and was involved in all aspects of the home. They undertook shifts, cooked meals and administered people's medicines on a regular basis. The provider was focused on ensuring people enjoyed their life at West Farm House and were happy with the service they received.

People were complimentary about the staff, the provider and the home in general. They liked the homely, relaxed approach, being able make decisions and follow their preferred routines. People told us they enjoyed the meals provided and had enough to eat and drink. All meals were cooked "from scratch" and based on fresh produce but there was no choice of main meal. People were given alternatives if they did not like the meal provided. People told us staff responded to them quickly during the day and had sufficient time to chat. They were able to give their views about the service they received and knew how to make a complaint. People and their relatives were confident any issues would be quickly and satisfactorily resolved.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of the Care Quality Commission (Registration) Regulations 2009. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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.

Potential risks to people's safety were not being identified and satisfactorily addressed.

Whilst there were enough staff to meet people's needs during the day, this was not the case at night. The absence of waking night staff placed some people at risk of harm.

Medicines were not safely managed.

Documentation did not demonstrate safe recruitment practice was being followed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had completed a range of training but not all courses had fully equipped them to undertake their role more effectively.

People were assisted by staff who felt valued, were well supported and knew them well.

People had enough to eat and drink. All meals were cooked "from scratch" with fresh produce. A choice of meal was not formally available, although alternatives were given if required.

People had capacity to make decisions and where uncertainties arose, further advice about the requirements of the Mental Capacity Act was being sought.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Practices, which resulted from the lack of waking staff at night, did not promote some people's dignity.

People and their relatives spoke positively about the staff and their caring, friendly approach.

People were able to follow their own routines, with an emphasis on promoting independence.

Staff spoke and interacted with people in a caring and attentive manner.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People's changing health and personal care needs were not being adequately identified and addressed.

Care planning was insufficiently detailed and did not reflect people's individual needs or the support they required.

The home's policy on social activity provision did not fully relate to people's expectations and wishes.

People and their relatives were happy with the service they received. They felt confident in raising any concerns they had. However, the formal complaints procedure did not promote confidentiality, which increased the risk of issues not being raised.

## Is the service well-led?

**Inadequate**

The service was not well led.

The quality auditing systems were not effective in identifying shortfalls within the service. Those issues, which had been identified, were not properly addressed or resolved.

Not all management systems were effectively performed. For example, staff did not have a clear understanding of the fire panel and fire instruction and fire drills had not been regularly undertaken.

The registered manager had a "hands on" approach, was visible and had a strong ethos of wanting people to be happy.

People were encouraged to give their views about the service either informally or via questionnaires.

# West Farm House

**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 was unannounced and took place on 14 and 16 June and 4 July 2016. The inspection 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.

In order to gain people's experiences of the service, we spoke with nine people and two relatives. We spoke with the provider, four members of staff and a health care professional. We looked at people's paper records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to us on time.

Inadequate

# Is the service safe?

## Our findings

Risks to people's safety were not being adequately managed. The hot water from hand washbasins in people's en-suite bedrooms, the downstairs toilet and the bathroom exceeded 50°C. Records showed these temperatures were a regular occurrence and presented a risk of scalding. However, action had not been taken to regulate the temperature so it was at a safe, recommended level of 43°C. After drawing this to the attention of staff, a plumber was called to reduce the temperature of the water. The plumber adjusted the regulator on the boiler but the temperature of the water remained high. The provider told us in the past, all hand wash basins had been fitted with regulators but these were taken off when told they were no longer required. The provider told us they would contact the plumber again to discuss what action was required, to ensure the water was maintained at a safe temperature.

There was a hot pipe, which ran just above the skirting board in the downstairs toilet. This was not covered and caused a risk of scalding if a person touched or fell against it. On discussing this with the provider, they told us the pipe would be covered to minimise such risk. There were radiators in central areas such as corridors and the downstairs toilet, which were uncovered and presented similar risks of harm. Recently reviewed risk assessments showed hot water outlets were to be fitted with regulators and radiators required covers to minimise potential risk. This action had not been taken. There was a bolt type lock on the inside of the downstairs toilet door. This did not enable staff to gain easy access to the room in the event of an emergency. On return from their leave, the provider told us the lock had been removed.

The fire panel was located in the kitchen and showed the home was divided into zones. Once the fire alarms were activated, the location of the fire was identified according to the highlighted zone. However, the fire panel was not labelled and staff were not aware which areas of the home the zones related to. This presented a delay of locating the fire in an emergency. Staff addressed this during the inspection and labelled the fire panel appropriately. There were a number of fire doors, which were held open inappropriately with wedges. This restricted the doors from closing automatically if the fire alarm was activated. In addition, holding fire doors open inappropriately without an approved device, caused damage to the door's alignment. This affected the door's ability to withhold smoke in the room, to stop it spreading. On the last day of the inspection, the registered manager told us they had removed all door wedges from the home and had applied new batteries to the door guards. This enabled the doors to be held open appropriately and safely. Fire safety records showed some doors did not close properly when the fire alarm was activated. These faults had not been addressed. The provider told us this was because the faults were intermittent and difficult to act upon. They said they would ensure an external contractor visited to rectify the problems.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities to report any allegation or suspicion of abuse. However, details of the local safeguarding team were not prominent and not identified on the list of contacts the provider gave staff, whilst they were on holiday. One member of staff told us they had contact details of a social worker, so

would inform them if there were any problems. They told us if anything serious arose, they would contact the provider for further advice. The provider confirmed they were in regular contact with the home whilst away, so would inform staff of any action, which needed to be taken in their absence.

Whilst people told us there were enough staff to help them during the day, there were not enough staff to meet people's needs effectively and safely at night. This was because some people had night time care needs but there were no waking night staff to support them. During the day, people told us "there's a lot of staff per head", "if you need help, someone comes" and "if you call, staff respond". At night, a member of staff worked until approximately 11pm and then settled people for the night. They slept in the office but were available if called or in an emergency. Some people were not able to use their call bell. This meant the "sleeping in" member of staff would not know if such people were unwell or needed assistance. Records showed one person was at risk of falling but often walked around the building at night, without staff support. Information indicated staff only knew the person had done this, as internal doors were often open in the morning. The person's care plan stated they were unsafe when using the stairs. However, the person had a bedroom on the first floor, so were at risk of falling down the stairs if not supported. The person's care plan stated they were also at risk of leaving the building unsupported. Information did not state how this risk was being minimised. Three people needed assistance with their continence care at night and one person required assistance with repositioning in bed, to minimise their risk of pressure ulceration. This support was not given as there were no waking staff to assist. This did not ensure people's needs were met and their safety assured. One member of staff told us they believed waking night staff were now required in response to people's changing needs. They were concerned that staff did not really know how long people had been waiting for assistance or had been lying in wet clothing, if they had needed the bathroom. The provider told us they were aware of these risks and were looking at ways to ensure people's safety during the night. After the inspection, the provider told us they were talking to staff about undertaking waking night shifts. They confirmed waking night staff would be deployed, as soon as it could be arranged.

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

Records showed there were two care staff on duty throughout the day with a cook working from 8am until 2pm. Staff told us this was sufficient although with people becoming frailer with additional health and personal care needs, having two staff on duty was becoming more challenging. Staff told us in addition, they were responsible for all cleaning duties. They told us they felt a specific cleaner would be of benefit and would enhance the time they spent with people. The provider told us they employed a member of staff to complete tasks such as cleaning the brass, but would look into the possibility of employing further housekeeping staff.

Staff had received infection control training yet good infection control guidance was not being followed. The washing machine and tumble drier were located in an outside building. There was a large build-up of dust behind the machines and leaves and cobwebs around the room. There were empty jars, tins and recycling bins next to the machines. The walls and floors could not be wiped hygienically clean. Staff used different mops to clean different areas of the home. The mop heads were discoloured and there was no formal system to ensure they were regularly washed or replaced. Outside the laundry room, there was a bowl containing soiled items. A member of staff told us soiled clothing was always soaked, before putting it in the washing machine. This was not good practice. They said all laundry and soiled items were carried to the laundry in bags. The items were then sorted and washed accordingly. The member of staff told us in their last job they used "red bags" to transport soiled or infected laundry, but these were not used at West Farm House. Red, dispersible bags are specifically designed to minimise cross infection. This is because the bags can be placed straight in to the washing machine, without frequent handling of the soiled items.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely. Boxes of people's prescribed medicines were stored in plastic containers in a trolley, in the kitchen. These boxes were placed precariously, inside the trolley, which increased the risk of them being mixed up. Within the bottom of one container, there were two loose tablets and a sleeve of medicines. These were not stored appropriately. There were two bottles of liquid medicines on the work top in the kitchen. These were not stored securely. The trolley was not securely fixed to the wall. Staff told us the trolley was secured at night but not in the day when staff were in the vicinity. This did not ensure medicines were kept safely at all times. The trolley was kept in the kitchen, near the 'range style' stove, which was very warm. This meant there was a risk that the effectiveness of the medicines was affected by the warm temperature. The temperature of the kitchen was not routinely monitored to assess this risk. Later in the inspection, the provider told us arrangements were being made for the trolley to be stored elsewhere. Some medicines, which needed to be kept at a low temperature, were stored in a refrigerator. The medicines were stored in a separate compartment from food items but a risk of contamination remained.

All medicine administration records were handwritten but not signed or countersigned by another member of staff. This increased the risk of error. After the inspection, staff arranged for the records to be pre-printed by the local surgery. There were some gaps in the medicine administration records, which did not show people had been given their medicines, as prescribed. Staff had not clearly recorded the variable doses when administering some medicines. One person had been prescribed a patch, which was applied to their skin. A record was not maintained to show the accurate rotation of the patch. Another instruction showed a medicine was to be taken with or after food but it was given to the person at night. This increased the risk of possible side effects or the medicine not being absorbed properly.

Some people had been prescribed topical creams but information did not clearly show the directions for their use. Staff had not signed the records to show they had consistently applied the creams. There were some medicines, which had been prescribed "as required". Whilst people were able to ask staff if they needed these, there were no protocols to ensure the medicines were administered, as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records did not evidence a robust recruitment procedure. Out of five personnel files looked at, two did not have an application form and two did not have references, to show details of the applicant's past work performance or personal qualities. Of those references in place, the capacity of the person providing the reference was not clear. It was therefore not possible to see if the applicant had selected the most appropriate person to provide the reference. For example, one application showed a reference from the applicant's colleague rather than their manager. The reasons for this were not documented and expanded upon. Not all information such as application forms and contracts of employment were appropriately signed and dated. One member of staff undertook weekend work and was a relative of another member of staff. There was no documentary evidence to support this person's application.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service effective?

## Our findings

Records showed staff were up to date with their mandatory training. Such subjects included safeguarding people from harm, infection control, the safe administration of medicines, basic life support and food hygiene. Staff had not received training in topics related specifically to older age, such as skin integrity. This meant that staff were not aware whether a person needed support with repositioning, if they had a specialised pressure relieving mattress. Staff had to ask a health care professional who told staff this intervention was still required. The health care professional supplied documentation to assist staff with documenting the care they gave, to minimise this person's risk of pressure ulceration.

Whilst a range of topics had been completed, not all courses assisted staff to do their job more effectively. For example, staff had undertaken training in moving people safely but the course did not involve practical techniques to enable staff to apply their learning. A member of staff had asked for more knowledge about this area and this had been given. However, the member of staff who gave this instruction was not qualified to do so. This was because their manual handling "train the trainer" qualification had expired. Staff told us a hoist had recently been delivered to support one person to move safely. They said the hoist came with instructions but no formal training was initially provided. This placed the person at risk of harm. Once this shortfall was identified, a health care professional arranged training sessions for staff. Staff told us the local authority was also providing the team with effective record keeping training. There was a training matrix, which showed the courses staff had undertaken. In addition, each member of staff had a development file, which contained certificates of the training they had completed.

The provider told us staff training was undertaken "on line" whilst other subjects were covered "in house". They said staff had recently undertaken "looking out for sight" training, which was enjoyed by all. The provider told us this training was experiential and had involved wearing a range of specialised glasses to experience the different types of sensory loss. The provider told us new staff were currently undertaking their induction. Due to the comprehensive nature of the new induction programme, the provider told us they were encouraging all staff to complete it, as a means to further enhance practice.

Staff told us they received sufficient training to enable them to do their job effectively. They said they felt supported and were valued by each other and the provider. Staff told us they discussed issues regularly due to being a small team. They said this enabled good communication and a clear awareness of what was going on in the home. Staff told us they regularly saw the provider and had more formal meetings with them, to discuss their performance and any concerns. Staff told us the meetings were productive but they also raised issues informally on a day to day basis, as required. The provider confirmed they aimed to meet with each staff member more formally, on a two to three monthly basis. They said these sessions were productive, helped staff to reflect on their work and "hammer out" any issues. Records showed there was a similar format for each meeting, to ensure all staff received the same messages.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider told us they had undertaken training in relation to the MCA. They said until recently, they had not submitted any formal applications to the local authority, as they did not feel they needed to do so. They said this was because there were no restrictions within the home and people had the capacity to make their own decisions. The provider told us people were able to "come and go" as they pleased and follow their own routines. They said people had chosen to make West Farm House their home and could decide what care and treatment they wanted. However, whilst discussing this with another agency, the provider was told they needed to submit DoLS applications for those people going out unsupported. This was because people were asked to tell staff when they were going out and when they would return. The provider told us they were planning to gain further clarity about this, as they believed people had capacity and asking them about their whereabouts was general courtesy, not a restriction.

The provider told us one person's needs had recently changed. Discussions with other agencies indicated a monitor was required at night, to enhance the person's safety. The provider told us the monitor was in the process of being legally authorised under the MCA. Records showed staff had undertaken training in the MCA. Staff told us they always asked people's consent before undertaking any task. One member of staff told us "it's their choice. We can't take that away from them. If they want to do something and they have capacity, we have to give them the information so they can make a proper decision, but it's up to them". However, within one person's records, a restriction on visiting was noted, following an instruction by a person's relative. The record did not show this decision had been made in line with the MCA.

On the day of the inspection, people were served pork casserole, potatoes and fresh vegetables for lunch with pear flan, as a dessert. Whilst the meal looked appetising and had been cooked "from scratch" with fresh ingredients, there was no choice. Two people raised this with us. One person said "there's not a choice of meal or a menu to inform you what you'll be eating although they will give you an alternative, if you don't like the main meal". Another person told us "I take what comes". Staff confirmed people would be offered an alternative if they did not like what was served, although said people generally liked all foods. They said people were often asked if they wanted anything special to eat. Any requests were then added to the shopping list and provided accordingly. One member of staff gave the example of a person liking kippers so they often had that for their supper. The registered manager told us people were not "fussy eaters". Staff told us there were no special diets related to people's ethnicity or health care needs. However, one person had decided to eat less calorie filled cakes and desserts with the aim of losing weight. Staff told us they kept a record of each person's food consumption so they could monitor people's weight. They said any concerns would be discussed with the GP. These records were detailed. One person had a fluid chart as they were not drinking well after a period of ill health. Whilst the fluid chart showed staff regularly supported the person to drink, the amounts were not totalled on a daily basis, which did not enable easy monitoring.

People told us they liked the food and had enough to eat and drink. They said the food was "good", "excellent", "wholesome and eatable", "very nice", "good old nursery food", "varied" and "it's all freshly produced". Other comments were "Helen (the provider) is a good cook", "there are plenty of vegetables, which is nice" and "you can have strawberries if you don't have a pudding". One person told us they enjoyed having eggs and bacon in the morning although another person did not know a cooked breakfast was provided. Another person said they had porridge and muesli and toast with jam. Relatives confirmed the

food was good. One relative told us "the food is good. It's good home cooking".

Before the inspection, a safeguarding alert had been made as it was identified a person had not received appropriate medical intervention, in a timely manner. A lack of detail within the person's records did not demonstrate whether this was the case. Staff told us people received excellent support from the two local surgeries. The provider confirmed this and said the community team was "absolutely fabulous. Even the receptionist knows people by name". They said due to being within a village, people regularly saw the same GP and knew them well. Staff confirmed the GP's and community nurses were regular visitors and always came out when requested. One relative confirmed staff had requested medical advice for their family member when unwell. Records showed people were supported to receive services such as chiropody, optical care and dentistry. Staff told us one person was receiving a high level of specialised support, in response to their changing needs. This included regular visits from a physiotherapist and occupational therapist. They told us the physiotherapist had completed a manual handling plan for the person and would be "dropping it in" very shortly. One health care professional told us staff always made appropriate referrals and asked for advice when they were not sure of anything. They said staff "ran things past them", followed instructions they gave and were aware of people's needs.

Requires Improvement

# Is the service caring?

## Our findings

People's dignity was not always promoted. This was because some people had continence needs, which were not being met. One person told us they needed assistance to go to the bathroom during the night, as they were concerned they would fall. However, as there were no staff available to assist them, they told us they passed urine in their continence aid. The person told us "it's like going back to being a baby but never mind, that's the way it is". Records showed other people needed assistance to remain continent but at night, this was not given. The information showed there had been occasions, when staff had found people soiled in the morning when they started their shift. This not only compromised people's dignity but also increased their risk of skin damage and emotional wellbeing. One record showed a person was found asleep in the hallway, when staff started their shift in the morning. The person explained they had not been able to find their way back to their room, so had waited for assistance. This again, did not promote their dignity or overall wellbeing.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the staff. They described the team as "friendly and casual", "caring and competent", "wonderful, very pleasant" and "nice, helpful, gentle, disciplined". One person told us "all the staff are caring. They always do their best and will help in any way they can". Another person told us "caring? Yes, they are. The staff and Helen [the provider] are very caring". Relatives were equally positive about the staff. One relative told us "they're all great. They're like a part of my family really. It's so friendly and relaxed here. I'm really pleased with everything. X is very happy here. We're nearby so we can just pop in at any time or take X out. They'll also keep me informed of anything so I don't need to worry. It's a lovely home". Another relative told us "it's very homely and they're very caring. The home is quiet and calm, which keeps people calm. It's a nice atmosphere and everyone is content. They look after X very well".

People told us they liked their room. They said they were able to bring items of furniture and personal possessions with them when they moved in. People told us this made their room "more homely" and "like home". People told us they were able to spend time in their room if they wanted to. They said they usually came down to the dining room for meals so they could meet up with others for a chat. People told us staff would deliver their meals to them in their room, if they did not want to use the dining room. One person told us "sometimes I eat here in my room. They don't mind bringing it to you. They're all very obliging".

People told us they were able to follow their own routines and be as independent as they wanted to be. One person told us they liked to do general household chores such as making their bed and dusting their room. They said they were on their way out to water the flowers. They said they did not want the flowers to die, before the provider returned from their holiday. The person told us they liked to do a "spot of weeding" to help out where they could.

The provider told us promoting people's independence was an important factor of the home. They said it was important to make people happy and to ensure they enjoyed their time at West Farm House. The

provider told us they promoted a homely atmosphere and a good standard of accommodation to enable people to be comfortable in their surroundings. This included flowers on the table in the hallway and in the lounge. They felt this was important, as a "nice environment" enhanced people's wellbeing.

Staff spoke and interacted with people in a friendly, caring way. Staff answered people by saying phrases such as "you're very welcome, I'll see you in a minute". There was a lot of general conversation, which people appeared to enjoy. One person was looking at the newspaper and discussing particular issues with a member of staff. Another member of staff assisted a person to their room in a reassuring way. At lunch time, people were asked if they had sufficient to eat or whether they wanted more vegetables. A member of staff offered gravy and other condiments and then asked where they wanted these to be placed. Pleasantries such as "enjoy your meal" were given and staff withdrew to the kitchen to enable people to eat quietly, whilst maintaining privacy.  Staff were confident when discussing how they promoted people's rights to privacy, dignity, choice and independence. This included "not administering people's medicines whilst they were eating", "not cutting up people's food in front of others" and "not rushing people". One member of staff told us they always ensured they gave people time, undertook personal care in private and respected the fact they were in people's homes. Another member of staff told us they tried to "enable people to live as they wanted to".

Inadequate

# Is the service responsive?

## Our findings

People's changing needs were not adequately identified and addressed. One person told us "this is a retirement home not a care home". Another person told us "people aren't as fit as they used to be and their memories aren't so good. This is difficult as you end up telling people all the time, what or where they need to go. It can be tiring". Another person told us "you are encouraged to look after yourself".

On the first day of the inspection, one person was being supported by their family to attend day surgery. Staff knew the person would be returning to the home at approximately 6pm but did not know the reason for the surgery or the support they might need on their return. This did not enable any precautionary measures to be put in place, to ensure the person's wellbeing. Another person required increased support in terms of their mobility, eating, drinking and skin integrity, due to deterioration in their health. Their night time care needs were identified as similar to those in the day. However, changes to staffing arrangements, had not been made to address these. One member of staff told us they believed some people now required additional support due to their changing needs. This had not been considered. After the inspection, the provider confirmed attention was being given to this.

Each person had a care plan. However, the documents were limited in their detail and did not reflect people's needs or the support required. There were phrases such as "I need assistance with mouth care", "I need a little assistance from one person with some aspects of personal care" and "I have several conditions that cause me difficulties". Other phrases included "my skin is dry. I like/need to have cream applied" and "I need support getting to the toilet". The lack of clarity within information did not clearly inform staff of the support each person required.

Care plans had not been updated fully to reflect the changes in people's needs. For example, a risk assessment to identify the person's manual handling needs had not been undertaken. Information showed two members of staff were required to assist the person to move safely. However, the equipment required was not stated. There was not a plan to inform staff of the support the person needed and the potential risks involved. A record of health care professional visits showed the person required a "texture E fork mashable" diet and of normal texture, if staff were present in the room". This was not detailed in the person's care plan and an assessment in relation to the risk of choking, had not been completed. The person was not receiving support to change their position regularly to minimise their risk of pressure damage. At night, a mattress was placed on the floor, to minimise injury if the person fell out of bed. This was not a pressure relieving mattress, so there was a risk this would have caused the person harm, if they had led on it for any period of time. Records showed the person had fallen but had not been found until the morning. As there were no waking night staff, it was not clear how long the person had been on the floor. During the inspection, the person's pressure relieving mattress was bleeping and showing a fault. Staff told us a health care professional had checked the mattress and no issues could be found. No further action had been taken to resolve the fault that was showing.

There were some aspects of people's health and personal care needs, detailed in various other sections of the records. Not all had a plan of care to show how they would be addressed. For example, one record

showed a person had a "red area" and "a pressure sore" but there was no further detail about how this was to be managed. Another record showed a person was at risk of developing urinary tract infections. The information did not detail what action was required to minimise this risk. Another record stated "I am at risk of falls" but there was no information to show how the person's safety was being promoted. One person had seen their GP to manage constipation but bowel care was not detailed within their care plan.

Each file had a one page profile, which contained headings such as medical history, "what is important to me" and "how best to support me when I need help". However, not all profiles were fully completed. There was some information in other parts of the care plan about people's personal preferences and their life history. This was person centred and identified preferences such as enjoying classical music, the countryside and contact with the church. The provider told us they had recognised people's care plans were not "fit for purpose" and could be improved upon. They said they were currently receiving assistance from the local authority's Quality Team to review the plans and to introduce a new format, which would accurately reflect people's needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed living at West Farm House. They said they liked the staff, the environment and the homely atmosphere. One person told us they enjoyed the relaxed approach and being able to make their own decisions. They said they did what they wanted to do, which promoted their independence. Another person told us "it's a very small home so it feels like home. It's very nice. You can have your time alone but can also spend time with others. You have the best of both worlds and the security of staff being there, if you need them". Another person told us "it's lovely here. It's like being in your own home". People told us they regularly went out with their family or entertained visitors in their room. One person told us they liked to pick flowers from the garden and sometimes walked to the local shop. Other people told us Holy Communion was held in the home and staff were accommodating to visitors, including those from the local church. A relative told us they liked the home, as their parent could help with household tasks, such as washing up. They told us "It's like home from home. A home but with support. They're all like members of my family".

During the inspection, there was no organised activity taking place, which people could join in with. People spent time in the garden room with the patio doors open, watching and listening to the birds. One person said "listen, just listen. Nothing but peace and quiet and the quiet tones of the different birds. Beautiful". Another person told us "the garden is glorious, lovely to look at. Helen [the provider] does a good job with keeping it so nice". On the table in the entrance hall, there were village magazines and contact details of the local taxi services.

There was a policy, which detailed activity provision. The information stated "Our client group are not receptive at all to the idea of activities. Most of them have independent minds and interests that they like to pursue in their own rooms, at their own pace". The provider told us this remained accurate and people did not like the idea of "activities", as they had "school like" relevance. However, whilst acknowledging this, some people told us the quiet nature of the home, had its "flip side", which was not so good. Specific comments included "there's nothing to do here. No entertainment", "there's not a lot going on. You need to get a taxi to get anywhere due to the distance involved" and "there's nothing else to do". One person told us they used to go to church but this no longer took place. Another person told us "if the girls [staff] are free, you can go for a walk but there are no paths, so it's not easy". The provider told us they would discuss activities with people and would try to arrange any suggestions, they came up with.

People told us they would speak to the provider if they were not happy about any aspect of the service. They told us "Helen [the provider] takes notice if you complain and it's dealt with" and "if there are any problems, Helen will do her best to deal with them". Another person told us "if you complain, you are heard". One person told us they knew how to make a complaint but did not feel the need to do so. They told us "there's nothing to complain about but a lot to praise". Relatives told us they would raise any issues informally within discussion, either with staff or the provider. They did not feel their concerns would escalate to a formal complaint. One relative told us "you only need to say and talk it through and they will sort it".

The provider told us a copy of the home's complaint procedure was given to people on their admission. They said any concerns, no matter how small, would be properly investigated and resolved. Information within the complaints procedure stated anyone wishing to make a complaint should do so by writing in the "Compliments, comments and complaints" book. If this could not be found, they should ask staff for its whereabouts. The book was on the table in the entrance hall. It contained compliments, the last of which was in March 2016. Regular entries in the book had not been made. Whilst clearly accessible to people, the process did not ensure confidentiality. This increased the risk of people not making a complaint, if they wanted to.

Inadequate

# Is the service well-led?

## Our findings

Records showed an audit took place on a monthly basis. The audit monitored areas such as making sure equipment including walking frames were clean and staff wore protective clothing appropriately. However, the audits were not specific to different aspects of the service, such as the standard of the environment, medicine management and infection control. In addition, the quality auditing system was not effective in identifying shortfalls, as identified during this inspection. This included the management of risk and good infection control practice, as well as risks associated with inadequate staffing levels and poor record keeping.

There were records which showed the provider undertook a monthly summary of events, accidents and any contractors that had visited. This gave an overall, "at a glance" portrayal of activities, for monitoring purposes. Other records showed care plans had been reviewed. However, there was no detail to show which plans had been checked and what was found. There were no action plans to formalise improvement.

Whilst some shortfalls had been identified, they were not being satisfactorily addressed. This included the ongoing identification of excessively high water temperatures, without any action being taken. In addition, it had been identified that some fire doors had failed to close properly and there was a fault with a person's pressure relieving mattress. Neither area had been properly resolved. The provider had not taken action to address these areas.

Not all management systems were being effectively undertaken. For example, staff told us they monitored the temperature of the water before supporting a person to have a bath but did not record this information. Records did not show effective monitoring of equipment such as the emergency lighting, to ensure it was in good working order. Fire safety records in relation to the visual checks of the fire-fighting equipment and means of escape had not been completed. Not all staff had received up to date fire instruction and records showed the last fire drill had taken place between July and September 2015. This did not demonstrate quarterly checks, as stated in the fire safety records.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed external contractors had regularly serviced items such as the passenger lift and fire alarm system. The water supplies had been checked for legionella and small portable appliances had been tested to ensure they were safe to use. The provider told us a kitchen inspection had been undertaken and all requirements identified had been undertaken .This included new flooring in the kitchen and redecoration of the utility room. They said in addition, a new carpet had been fitted to the lounge, hallway and landing and Wi-Fi had been installed.

The provider told us quality auditing systems were not an area of their expertise. They said they often addressed issues, without documenting they had done so. The provider told us they welcomed feedback about existing auditing procedures and would use this to enhance improvement. They said they tried to

lead by example and ensure staff knew the right way to do things. They said they were very "hands on" and regularly worked alongside staff, so were aware of people's needs and the support required. The provider told us they completed a morning shift, a sleeping in duty, cooked lunch on a Sunday and regularly administered people's medicines. They said this enabled them to be familiar with people, visitors and staff and not to "lose touch" with what was going on. In order to achieve this further, the provider told us they had moved their office from the adjacent cottage, to a room inside the home, near the kitchen.

The provider told us they had a mix of management styles but predominantly, they were "free and easy". They said their main focus was to ensure people were happy living at West Farm House and were content with their lives. They said they aimed to enable people to lead independent lifestyles based on individual wishes and preferences. The provider told us they felt lucky to have the staff team, as they were all conscientious and had a different area of expertise and skill. They said they aimed to keep staff happy, as "Happy staff made happy residents".

People told us they had regular contact with the provider. One person told us "Helen [the provider] comes in with my tablets in the morning, to check if I'm okay". Another person told us "She is here all hours of the day. She's very visible and helps out. She also cooks on a Sunday". Another person told us "I like Helen very much. She is always around and very much part of the home". Other comments were "Helen is open to seeing people", "Helen is very good in her job" and "Helen is very available. She is a good friend". Relatives were also complimentary about the provider and their management of the home. One relative told us "Helen is on to everything. It's a lovely place". Another relative told us "I have nothing but praise for the staff and Helen. We often have a chat about how things are going. Helen is on top of things and knows exactly what is going on. It's also very relaxed and homely, it's all good. I'm very happy".

The provider told us they aimed to keep up to date with current practice by researching information and being part of forums such as the Care Homes Association. They told us however, that due to being a sole provider, without other services or departments as within organisations, this was not always easy. The provider told us they had an external consultant, which they contacted for advice when required and were currently working with the local authority's quality team. They told us they regularly asked people for their views about the service they received. This was undertaken informally through one to one discussions. More formally, people, their relatives, staff and health care professionals were given questionnaires to complete on a regular basis. They said staff assisted people to complete the questionnaires, by asking the questions and documenting the answers. Whilst acknowledging this, there was a risk that this format, did not encourage people to be open and share their views readily. There was a file, which contained a range of completed questionnaires. The feedback received was predominantly positive and gave complimentary comments about the service. However, the feedback had not been coordinated or displayed, so people could see the information "at a glance".

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Some people's dignity was not promoted, as they were not sufficiently supported to meet their continence needs at night. Regulation 10(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Safe recruitment procedures were not being followed, as insufficient information was sought about applicants before they were appointed. Regulation 19(1)(2)(3) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Potential risks to people's safety were not being identified and addressed and the provider was not always responsive to people's changing needs. Care plans were insufficiently detailed and did not reflect people's health and care needs or the support they required Regulation 12(1)(2)(a)(b). Medicines were not being safely managed Regulation 12(1)(2)(g). |

**The enforcement action we took:**

We issued a warning notice in relation to breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Auditing systems were not effective in identifying and addressing shortfalls in the service. Management systems were not always effectively undertaken. Regulation 17(1)(2)(a)(b) |

**The enforcement action we took:**

We issued a warning notice in relation to breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing levels were not sufficient during the night to ensure people were protected from harm and their night time care needs were met. Regulation 18(1) |

**The enforcement action we took:**

We issued a warning notice in relation to breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated