Ashcroft Care Services Limited

Tanners Farm

Inspection report

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Date of inspection visit: 26 October 2015
Date of publication: 03/12/2015

Ratings

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

Overall summary

Tanners Farm House is a care home which provides care and support for up to seven people who have a learning disability, such as autism. At the time of our visit there were four people living at the home, all of whom were male.

There was no registered manager in post. The new manager was in the process of applying to become the registered 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 and associated Regulations about how the service is run. The manager assisted us with our inspection on the day.

Proper medicine management procedures were not always followed by staff. We found one person had not received their medicines and one medicine was not labelled or dated.

There were enough staff working to meet people's needs. Staffing levels were such that people were not kept waiting when they needed care and support. People were enabled to go out or remain in the home because of the staffing levels. However, we found staff were not always deployed appropriately in the home.

Summary of findings

Staff were not provided with regular training to assist them with carrying out their role and staff did not have the opportunity to meet with their line manager regularly to check they were following best practice, or to discuss any aspect of their work.

Staff did not have a good understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, which meant people had restrictions in place without the proper procedures being followed.

Accidents and incidents were recorded and monitored by staff to help ensure they could mitigate against further incidents happening. People's dietary requirements had been identified by staff and these were taken into account when developing the menus or doing the shopping. However, people were not involved in choosing their meals and the food they would like to eat.

Quality assurance monitoring wasn't always completed as often as it should be and actions from provider visit audits had not always been addressed by staff.

We found that where there was a risk to people this had been identified and action taken by staff. Staff had a clear understanding of how to safeguard people and knew what steps they should take if they suspected abuse. There was an effective recruitment process that was followed which helped ensure that only suitable staff were employed.

People were supported to access external health care professionals when required in order to help them maintain a good level of health. In the event of an emergency or the home had to be evacuated people's care and support would not be interrupted.

Staff showed people kindness and compassion. They recognised people's individual characteristics and respected their privacy when they wished it. Visitors were made to feel welcome in the home.

Meaningful activities were arranged for people and activities were flexible to fit with what people chose to do on a daily basis. Care records in relation to people were detailed and comprehensive and focused on the person.

Staff were involved in all aspects of the home and attended regular staff meetings. Staff felt supported by the manager and felt things were improving in the home now the new manager was in post. There was complaint information available for people should they have any concerns about the care they were receiving. Relatives were asked for their feedback in relation to Tanners Farm.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement 

The service was not consistently safe.

Staff did not follow robust medicines management procedures.

There were enough staff to meet people's needs, but they were not always deployed appropriately.

Staff were aware of the risks to people and how to manage them. Accidents and incidents were recorded and action taken when required.

Staff understood what abuse was and knew how to report it should they suspect it. Appropriate recruitment processes were followed.

Guidance was in place for staff and people should there be an emergency at the home.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Staff did not have a good understanding of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff were not provided with support in relation to their role, for example through supervisions. And staff had not always received the most up to date training.

People were not supported to be involved in developing the menus around the food they ate.

People had access to healthcare services to maintain good health.

Is the service caring?

Good 

The service was caring.

People were treated with kindness and compassion and their dignity was respected.

People were able to make choices where they could and were encouraged by staff to be independent.

Care was centred on people's individual needs. People's rooms were individualised and personalised.

Is the service responsive?

Good 

The service was responsive.

Care plans were extensive and contained relevant information.

Summary of findings

There were activities that were meaningful to people and people had the opportunity to meet with others out in the community.

There was complaint information made available to people.

Is the service well-led?

The service was not always well-led.

There was a lack of systems in place to monitor the safety and quality of the home.

People's views were sought on the care that was being provided by staff.

Staff thought the manager was supportive and they could go to them with any concerns. Staff were involved in the running of the home.

The manager was aware of their responsibilities.

Requires improvement

Tanners 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 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 was an unannounced inspection which took place on the 26 October 2015. The inspection team consisted of three inspectors.

Prior to the inspection we reviewed the information we had about the service. On this occasion we did not ask 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. Instead we reviewed all of the notifications of significant events that affected the running of the service. A notification is information about important events which the service is required to send us by law.

As people living at Tanners Farm were unable to tell us about their experiences, we observed the care and support being provided and talked to relatives and other people involved following the inspection.

As part of the inspection we spoke with the manager, two staff and two relatives. We spoke with one health and social care professional to gain their feedback as to the care that people received. We looked at a range of records about people's care and how the home was managed. For example, we looked at two care plans, medication administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed. We also looked at four recruitment files.

This was the first inspection of Tanners Farm.

Requires improvement

Is the service safe?

Our findings

People did not always receive the medicines they should have. We found one person's medicines still in the package from the previous day. We were told by staff this was because the person had been home and the medicines were given to their parents. We saw the medicines had been signed out to the parents and staff had ticked to say the medicines had been returned but had not counted them back in, therefore they were unaware that one dosage had not been administered. We also found a liquid medicine that had no label on the bottle and no record of the date it was opened.

The lack of robust medicine management procedures was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe medicines management processes were carried out by staff. We saw staff administer medicines to people and sign the Medicines Administration Record (MAR) after they were assured the person had taken their medicines. We reviewed other MARs and found these had been completed correctly, with no gaps. MARs had people's personal information on them and a photograph to ensure staff gave medicines to the correct person. We read guidance for staff to show how people liked to take their medicines and there was guidance in place for pain or allergy relief when relevant.

There were sufficient members of staff on duty to meet people's needs, however they were not always deployed appropriately. The manager told us that each person had a set number of hours of one to one support whilst in the home and some had two to one support when going out. We saw people were enabled to go out or remain in the home because there were adequate staffing levels to allow people to do this. We did not see anyone waiting to be assisted by staff and staff were always on hand to support someone when needed.

We heard however that staff allocations were done at the beginning of each day and although staff were keyworkers for particular people, they were not always allocated to them, meaning people did not receive consistency in relation to the staff member who care for them. We looked at the records and saw that staff allocation forms had not always been completed. We found people were unsure of who they had been allocated to. For example, we were told that three people had gone out in the morning, however we found two people had remained in the home. The member of staff who should have been supporting one of these people was unaware that they were still in the home.

The inconsistent approach to deployment of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Only suitably staff were recruited. Staff recruitment files contained relevant documents to show the provider had taken the necessary steps to help ensure they employed staff who did not have any convictions or employment history which meant people may be at risk. Documents included records of any cautions or conviction, two references, evidence of the person's identity and full employment history. Staff told us that before they started work they went through a recruitment process and had to provide evidence of their identity and background checks.

People were safeguarded from the risk of abuse. There was a safeguarding policy that guided staff on the correct steps to take if they had a concern and staff knew how to access this. Staff had received training in safeguarding people. Staff understood how to whistleblow if they had a concern that they wanted to report and knew about the role the local authority played in safeguarding people. There had been no incidents at Tanners Farm which had required the manager to submit a notification to us.

People were protected and their freedom was supported and respected which meant they could continue with as normal a life as possible but in a safe way. Risks to people had been identified. For example, we saw one person had assessments around all aspects of their care. This included a particular food allergy, travelling in the provider's bus, making snacks in the kitchen and their behaviour. Another person had risk assessments around falling because they liked to climb on furniture. Each risk assessments was detailed and informative and included measures that had been introduced to reduce the risk of harm. There was a swimming pool on site and each person had an individualised assessment around the risks related to the pool. For example, the risk of drowning.

Accidents and incidents were completed by staff and passed to the manager for analysis. Relevant actions were taken to help prevent reoccurrence. For example, we read two incidents relating to one person and the swimming

Requires improvement

Is the service safe?

being closed. We saw guidance had been produced and action taken to prevent further events. This had been successful and no further incidents had arisen since then in relation to this.

In the event of an emergency, such as the building being flooded or a fire, there was a contingency plan which detailed what staff needed to do to protect people and make them safe. There were personal evacuation plans for each person in their care plans. Following the inspection, the provider gave us a copy of the most recent fire risk assessment which had been carried out this month.

Requires improvement

Is the service effective?

Our findings

We found the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were not always being implemented appropriately. The MCA protects people who may lack capacity and ensures that their best interests are considered when decisions that affect them are made. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS ensure that people receive the care and treatment they need in the least restrictive manner.

The manager told us they were currently working through mental capacity assessments and best interest meetings paperwork, however they were unable to demonstrate to us a clear understanding of the legal requirements around this and DoLS. We looked at care records and found information in relation to one person which had been completed properly. For example, a mental capacity assessment had been carried out and a best interest meeting held. This had resulted in a DoLS application being submitted for them in relation to constant supervision by staff. However, another person who had a locked wardrobe in their room and could not access outside because of the locked gate did not have any of the required paperwork and the manager was unsure whether or not a DoLS application had been submitted.

The lack of following legal requirements in relation to the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may be cared for by staff who did not have the appropriate skills or training. The manager told us staff had, “A lot of training to catch up on.” This was confirmed by the training matrix given to us. It showed that of the eleven staff, seven had were out of date with health and safety training, six out of date with infection control training and six had not had recent fire awareness training. One newer member of staff had not undertaken any training at all.

Staff had not all received training specific to the needs of the people they cared for. For example, five staff had not had challenging behaviour training and six, epilepsy training.

Staff did not have the opportunity to meet with their line manager on a regular basis which meant they may not receive the support they need. We were told that staff had not received supervisions or appraisals in line with the provider’s policy. One staff member told us they had not had supervision for some months and another said they had not had any supervision's in the three months since they started working at the home. Supervisions and appraisals are important as they enable management to check staff are putting their training into best practice and they give staff the opportunity to discuss any aspect of their work with their manager.

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

People were not always involved in what they had to eat and drink. The weekly menu was written up by staff and this was based on staff’s knowledge of what people liked or disliked. We were told people were also offered a choice of meal on the day if they did not fancy what was on the menu. Pictorial menu cards were not used to encourage people to be involved in their own menu planning.

We recommend the provider support people to be involved in developing menus of their own food choices.

We saw people in the kitchen helping to prepare their lunch. We saw this was done whilst the shopping was being unpacked. People wandered around with food which was their choice. The menus showed a range of foods were offered to people and they could have fresh fruit if they wished it. We saw that people had access to snacks and hot and cold drinks when they wanted.

Where people had identified risks in relation to diet, staff took the necessary action. For example, staff were aware of one person who had a food allergy and they had taken this into account when they did the food shop and decided on the menu.

People were supported to maintain good health by staff. We saw evidence in people’s care records that external health care professional advice and input was sought when

Requires improvement

Is the service effective?

appropriate. For example, the doctor, dentist or a psychiatrist. This was confirmed by a professional we spoke with who told us they carried out an annual health check with people.

Good

Is the service caring?

Our findings

People told us that the staff were always caring. One relative said, "All is going well. He is happy in the home and is happy with the staff." Another told us, "He is always happy to go back to Tanners Farm after being at home."

People lived in a homely environment and individual's bedrooms were personalised with people's own belongings and items. The house had been nicely converted and was clean and comfortable. It had a 'young' feel which was suitable for the ages of the people living there.

Staff were able to anticipate people's needs and showed positive interaction with people. For example, one person said they wanted to go home and staff reassured this person by telling them when their next home trip would be. We heard this person repeat this question regularly throughout the day and always heard staff answer in the same tone and with patience. Another person had an itchy arm. Staff had noticed this and we heard them regularly gently advise them not to scratch it too much.

When people were anxious staff reassured them in a kind, gentle manner. We heard one member of staff telling a person, "It's okay" when they became upset. We heard the staff member repeating phrases back to this person to reinforce their reassurance. This reassurance was given in line with the guidance with read in this person's support plan and risk assessment.

Staff responded to people's needs appropriately. We saw people return from their morning shopping and saw staff greeting them in a welcoming way. We heard staff using intensive interaction techniques (repeating back) with people to help keep them calm and focused on the task of unpacking the shopping.

People could have privacy when they wished it. We saw one person liked to spend time in their room. Staff recognised their need for this and respected their wishes.

People's rooms had en-suites or a bathroom next to their room which meant they could have their privacy when it came to personal care. We observed staff always knocking on people's doors before they entered their bedroom.

People were encouraged to be independent and make decisions when they could. We heard staff ask one person if they would like a cup of tea and whether they or not they were looking forward to their dinner. A staff member told us they would offer up different choices of clothes for people to enable them to make their own decisions about what they wore.

Staff respected people's individual ways of communicating. For example, we were told by staff that one person used numbers to indicate their needs. A 'dictionary' of this person's signs and meanings had been included in their care records. There was a mixed use of picture symbols as the manager told us most people could, "Understand simple instructions." They told us people were able to make choices by choosing from a couple of options. However, for one person pictures had been introduced as this helped them to understand a particular instruction.

People's particular behaviours or triggers for raised anxiety were recognised by staff and action taken to help reduce them. Staff had set boundaries for one person which had reduced their anxiety levels because they now knew there were clear limits. Another person had emotional and behaviour support guidance in their care records for staff. This described the triggers resulting in this person's particular behaviour being displayed. Staff strategies included verbal reassurance, intensive interaction and music. Staff told us they assessed when the best technique to use would be and this worked.

Visitors were welcome in the home. Relative's told us they were always made to feel welcome. They said they were getting to know the staff and starting to develop relationships with them.

Good

Is the service responsive?

Our findings

One relative told us, “There is enough for him to do.” And another said, “He is going out more now. He needs lots of outings and being constantly out and about.”

Staff demonstrated they were flexible in their approach to meeting people’s needs. People were enabled to go out as much as possible and although there were set activities these were flexible and adapted dependent on how people felt. The manager told us there was no schedule of activities because, “People did not cope with structured activities.” However, he (the manager) told us they were working towards facilitating more structured routines for those people who liked them. For example, one person going out to buy magazines routinely and another going flying each week. Other people preferred music therapy, visits with family or going to a disco. There was a swimming pool on site and this was used regularly by two people. Staff told us many of the activities were physical because people living at Tanners Farm were young. For example, there was usually a bike ride each week and people liked going on walks. Other trips including going to the beach which one person in particular really enjoyed.

People were enabled to access the community and meet other people. Staff told us joint events were held with other Ashcroft homes, for example a BBQ or summer camp. This meant people could get to know people living in other homes and this helped them to develop relationships with them.

The approach to care planning and delivery was proactive and flexible to meet people’s individual needs. The manager explained that all new referrals for the home went through him. This meant he could ensure the dynamics of people living at Tanners Farm were right. He said the provider put him under no pressure to, “Fill rooms”, instead people’s needs were fully assessed to determine if the home was a suitable environment, staff could meet the persons need and if they would get along with other people living there. We read a pre-assessment in relation to one person who had recently moved into the home and found it to be very detailed and thorough.

Care plans were comprehensive and detailed people’s care needs meaning staff could provide care reflective of the most up to date information for that person. The records contained information on people’s dietary preferences, any food risks, individual goal plans and a personal profile. Support plans had been developed to record behaviour or emotional needs, financial arrangements, who was involved in decision making, communication needs, personal hygiene and activities. We read people’s preferences had been recorded. For example, we read someone preferred a bath, rather than a shower. And information for staff on how to plan a trip for this person was descriptive to ensure the person received the appropriate support when out.

Personal information contained in care records was detailed but sensitively recorded. For example, information around people with person care gave enough information for staff without it being too personal.

People had hospital passports in their care records. This was a document which recorded important information about a person should they have to go into hospital.

Complaint information was made available to people in a way they would understand. This was displayed clearly for people. The manager told us no formal complaints had been received since the home opened. They explained the complaint procedure for Ashcroft and said they knew there were timescales in order to respond to any complaints received.

Requires improvement

Is the service well-led?

Our findings

One relative told us, "It was a bit unsettling when the registered manager and deputy manager left within a short period of time of each other. But things are settling down now with the new manager who seems nice."

Quality assurance audits were not regularly carried out by staff and action taken. For example, we saw the last health and safety and water checks for the home were completed in August 2015. Weekly fire checks had only just been restarted after a period of these not being done. And the manager was unable to provide us with any further information about any other audits or checks carried out.

The provider undertook regular quality assurance audits to help ensure a good quality of care was being provided at the home and the home was a safe environment for people to live in. We noted the August 2015 had identified some areas that required action by staff and saw at our inspection these had been done. For example, ensuring that each person had a personal evacuation plan in place. However actions from the September 2015 visit had not yet been completed. For example, arranging staff training.

Staff told us that during the period when there was no registered manager at the home, they felt unsupported by Ashcroft. They said many of the systems in place with the previous registered manager did not happen and supervisions stopped.

The lack of proper quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said the new manager was supportive. One staff member told us, "He listens and acts." Another said, "Things are beginning to settle here. The manager is good. He is approachable and is doing a good job." The manager told us they had confidence in Ashcroft Care Services and they were being supported in their new role.

Staff were involved and kept up to date in the running of the home via team meetings. They told us they had regular staff meetings and felt confident to speak up in the meetings to offer suggestions or ideas. The meetings included discussion on all aspects of the home and gave the manager the opportunity to cascade any important information in relation to Tanners Farm or Ashcroft to staff.

Relatives were encouraged to give their feedback about the home. We looked at the result of the last relative's survey and saw one relative had commented, 'I would like to express sincere thanks to Ashcroft and the staff at Tanners for a brilliant start to my sons placement, Excellent!' We noted, this relative had also expressed a wish to make contact with their son via social media, but there was no internet connection at Tanners Farm. We spoke with the provider about this who told us this had been dealt with immediately.

Senior staff communicated through recruitment the values of the organisation which included people being supported to become more independent. One member of staff told us they were aware of the organisations mission statement and were informed of this when they applied for the role.

We saw that the manager was present and visible around the home throughout the inspection and the manager was aware of their responsibilities in relation to their role. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Although the manager had not yet had reason to notify us of any events, they were aware of their responsibility to do so.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured safe medicine management procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured suitable deployment of staff.** **The registered provider had not ensured staff were provided with appropriate training or supported in their role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had not ensured staff followed the requirements in relation to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured quality assurance monitoring was taking place regularly.**