Farmhouse Care Limited

Farmhouse Residential Rest Home

Inspection report

Talke Road
Red Street
Newcastle Under Lyme
Staffordshire
ST5 7AH

Tel: 01782566430

Date of inspection visit:
17 May 2016

Date of publication:
28 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 May 2016 and was unannounced. We had previously inspected in October 2014 and judged the service as being Inadequate. We had placed the service into special measures and issued a warning notice. We returned to inspect in April 2015 and found that although some improvement had been made the service still overall required further improvements. At this inspection we found that care being delivered was still not safe and people were at risk of harm due to the ineffectiveness of the management. We have judged this service as Inadequate and placed the service into special measures. We have also begun enforcement action against the provider.

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.

Farmhouse Residential Home is registered to provide personal care and accommodation to up to 23 people. At the time of the inspection 14 people were using the service.

There was a new manager in post, they were yet to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. People liked the new manager but expressed concerns over the regular change in managers.

The provider was not protecting people from the risk of harm through neglect as they did not ensure that staff delivering care were trained and competent. People were not being safeguarded from the risk of institutional abuse due to a lack of training for the staff supporting people.

People's medicines were not managed safely. People were not always given the correct dose of their prescribed medicine and some people had not been administered their medicine as the provider had not ensured sufficient stock was available at all times. There were insufficient suitably trained staff available to ensure that people could have their prescribed medicine when they needed it.

Risks to people were not always assessed and minimised. When risk assessments were in place, they were not always followed to ensure people were kept safe.

Staff did not receive the training they required to be able to fulfil their role effectively and people had experienced harm as a result of the incorrect use of equipment by untrained staff.

People's nutritional needs were not always met. Assessments of people's dietary requirements did not reflect the person's needs and they were at risk of malnutrition.

When health care advice had been sought for people, it was not always followed by staff to ensure that people's health needs were met effectively.

People right to confidentiality was not always respected by the staff team.

People did not receive care that met their individual needs and preferences and they were not always involved in the planning of their care. People were not engaged or stimulated by activities or their surroundings. Some people sat for long periods of time with no interactions.

Systems the provider had in place to monitor and improve the quality of the service were ineffective. People continued to receive Inadequate care following our previous inspections and input from the local authority.

The provider followed the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care.

There was a complaints procedure and people knew how to use it. People and relatives we spoke with told us that the provider and staff were kind and approachable.

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. People were not protected from abuse in the form of neglect as the provider did not ensure that staff were trained and competent to safely deliver care.

Risks to people were not assessed and minimised.

There were insufficient suitably trained staff to safely meet the needs of people who used the service.

People's medicines were not managed in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff were not suitably trained and did not always have the skills to meet the needs of those in their care.

People's nutritional needs were not always met and health care advice was not always followed.

People consented to or were supported to consent to their care and support.

.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always respect people's right to confidentiality.

People's personal belongings were not always treated with respect.

People told us they felt that staff treated them kindly and protected their privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive care that met their assessed needs. People were not offered opportunities to engage in activities of their choice.

The provider had a complaints procedure in place and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

Systems the provider had in place to monitor and improve the quality of the service were ineffective.

People were receiving care that was unsafe and the provider was in breach of several Regulations of The Health and Social Care Act 2008.

There was no registered manager in post.

Farmhouse Residential Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 May 2016 and was unannounced. It was undertaken by two inspectors.

We looked at previous inspection reports and we spoke to the local authority and gained their views on the service. They had concerns over the management and care of people who used the service.

We spoke with four people who used the service and two relatives. We spoke with the new manager, new deputy manager, the manager of a sister home, two care staff and two of the directors of the service.

We observed the care and support people received in the service. 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. We looked at the way in which people's medicines were managed. We also looked at people's daily care records and records of their medication.

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. We did this to see if they were effective in monitoring and improving the quality of the service.

Inadequate

Is the service safe?

Our findings

People did not always receive safe and appropriate care as people's risk assessments were not always up to date or reflective of their current needs. One person who lacked mental capacity due to dementia was in bed and staff informed us that they were respecting their choice to remain in bed. There was no risk assessment for this person remaining in bed and we saw they were at high risk of developing pressure areas due to their age, weight and dietary needs. There was no specialist mattress on the bed which may have helped to reduce the risk of pressure areas and although staff told us they changed the person's position every two hours we could not see records that confirmed that this was done regularly and safely. We saw that this person had a pressure mat by the bed, this was to alert staff to them moving as they were at high risk of falls. We found at one point during the inspection the mat was tucked under the bed and would not have been effective.

We saw that this person had been assessed by a speech and language therapist (SALT) as requiring a soft diet and needed to sit at the dining room table for their meals as they were at risk of choking on their food. On the day of the inspection we heard the emergency alarms sound and staff responded to this person in their room. We saw that they had been supported to eat in their bed and staff told us they had been given food pastry which was not soft and contrary to the SALT recommendations which state: High risk foods include, crumbly items such as bread, crust, pie crusts, crumble and dry biscuits. The person had begun to choke and staff had to take emergency action to support this person. This meant that this person was at risk of choking and harm due to staff not following the person's risk assessments and guidance from the health professionals.

On two occasions we heard the call bells ring for staff assistance. On both occasions we saw staff respond by going in the wrong direction of where the alarm had been sounded due to the call alarm sounding the same as the front door opening. This had meant a delay in staff responding to the person who had been choking. We spoke with one of the providers who said they recognised there was some confusion over the sound of the alarm and they were planning on installing a new panel. However this meant that people were currently at risk of not receiving support in a timely manner due to the confusion when the alarms sounded.

We saw on two occasions the laundry door had been left open. The laundry was situated on the ground floor along the corridor where people who used the service regularly accessed. Within the laundry we found machinery, hazardous substances and soiled clothing which could have presented a risk to people if they had accessed the room.

At our previous inspection we found that one person had missed having their medication for three days as the service had run out of stock. At this inspection we found seven people had at times not had their medication administered as it had run out of stock. Some people had been a period of two week without their prescribed medication. We also found that two people had missed their medication as they had been out on social visits with family, staff had not ensured that their medication went with them or they were administered it on their return. We saw that one person was prescribed different doses of one medication over a seven day period. We found that this person had been administered the incorrect doses of

medication over a period of three weeks and this could have been detrimental to their health and wellbeing.

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

We found that there were insufficient suitably trained staff to be able to administer people's prescribed medicines at the times they needed them. During the night time hours there were no medication trained staff on duty and one person had been refused their prescribed inhaler when they had requested it. The new manager told us that both they and the new deputy manager were now on call if people needed their medication, however this would mean a delay in people having their medication when they asked for it as they were not in the building and had to travel from their home addresses.

Some people required support with mobilising with the use of specialist equipment such as a mechanical hoist. One member of staff told us that they regularly supported people to move with the use of this equipment, however they had not received adequate training in its use and been assessed as competent. We saw records that confirmed that on two occasions this member of staff had been involved in accidents with people who used the service whilst using equipment to help them move, one accident had resulted in harm to the person. This meant staff were not trained appropriately to fulfil the roles expected of them and this put people who used the service at risk of harm.

We looked at the way the provider recruited new staff and found that on one occasion a new member of staff had started work prior to their references being gained. This meant that the provider could not be sure that they were of good character. We looked at rotas and saw that two new members of staff had been rostered to work together at night after only a two day induction period. This meant that the provider was not ensuring that suitably trained, competent staff were available at all times to support people and keep them safe.

These issues were a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not protecting people from the risk of abuse through neglect and poor care by ensuring that people were being supported by trained, competent staff and that people received their planned care in a safe way and their medication as it is prescribed. Following our inspection we had to raise safeguarding referrals for several people who used the service as the provider had not recognised that people were being abused through neglectful practices such as poor moving and handling, missed medication and poor nutrition.

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

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had noted some improvement in the way in which the provider met people's nutritional needs. However at this inspection we saw assessments that were in place for people were incorrect and potentially put people at risk of malnutrition or dehydration. We saw records of one person had been assessed at being at medium risk of malnutrition whilst actually their age, weight and mobility put them at high risk.

We saw another person who had been assessed as high risk of malnutrition and rehydration had food and fluid charts in place for staff to record what the person had to eat and drink. We saw on three consecutive days the person had very little to drink, but we could not see what action had been taken and the charts were not checked daily. This person's nutritional care plan was not followed in relation to them having a soft diet as they were given pastry on the day of the inspection and the local authority had reported that they had also previously been given biscuits to eat. This meant that people were at risk due to their nutritional needs not being effectively assessed and met.

These issues constitute a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us: "The staff noticed my relative wasn't well the other day and asked the GP for an appointment, they are very good like that". However we found that although the staff made appropriate referrals to health care professional for people when they needed it, they did not always follow their advice. For example, one person was being given food that put them at risk contrary to the SALT advice, people not being given their medication as prescribed by the GP or consultant and advice from a physiotherapist to implement a moving and handling plan had not been followed. This meant that people's health care needs were not always being met.

At our last inspections we had noted some improvements in staff training. However at this inspection we found that staff were not trained to a competent level to be able to meet the needs of people who used the service. Staff told us that they received training but we saw large gaps in the training schedule for staff. Some staff had not been trained to safely support to people to move and there were not enough medication trained staff to ensure people had their medicines when they needed them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw where there was any doubt people's capacity had been assessed to ensure they consented or were supported to consent to their care by a representative. A member of staff told us: "If someone doesn't want to do something, we can't force them; I would just go back and try again later".

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out

requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw that there had been several DoLS referrals made to the local authority to ensure that people were not being unlawfully restricted of their liberty.

Requires Improvement

Is the service caring?

Our findings

Some people who used the service were unable to tell us about their care due to their needs so we observed their care in the communal areas. We found that generally people were treated with dignity and respect although on a couple of occasions we observed staff talking about people's needs in front of other people who should not have been privy to that information.

We found a large mixed pile of unmarked clothes in the laundry, which no one knew who they belonged to. A relative told us: "Clothes have names in but they still go missing and turn grey when they are washed". This showed that people's personal items were not always treated with respect.

One person who used the service told us: "I like it here, the staff are lovely, I'm well looked after and they have got to know me well". Relatives we spoke with told us they liked the staff and the new manager was very friendly and kept them informed of how their relative was. We saw that a relative's meeting had been planned for the weekend. One relative told us: "I'm really looking forward to the meeting".

Staff we spoke with 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 confidentiality. We noted that staff carried out personal care for people within the privacy of their own bedroom or bathroom.

Requires Improvement

Is the service responsive?

Our findings

Although people had assessments of their needs they were not all up to date and relevant to their current needs. Some people were not receiving care that met their current assessed needs and this put them at risk of harm. On the day of the inspection a manager from another of the providers services was up dating some people's care plans. However they were doing this without the involvement of the people themselves or their representatives.

At our last two previous inspections we found that people were not offered hobbies or activities of their choice. At this inspection we saw that there were still limited opportunities for people to engage in any form of stimulating activity. One person who used the service told us: "I'm bored, I like to garden but I can't always get out there with the help I need". Another person told us: "We use to play bingo but that has stopped now". We observed other people who were living with dementia sitting in the lounge for the majority of the day. The TV was on but the sound was down so they could not hear it. When we asked they wanted it turning up which we did. The new manager told us that the staff member who usually supported people with activities was currently working night shifts. No activity plan had been put in place to cover this gap in activities staff.

There were no activities or entertainment on offer and the environment was not 'dementia friendly'. There were no visual prompts to orientate people to time and place and no reminiscence memorabilia available for people to stimulate their senses. Staff told us that people did not get the opportunity to access the community. This was discussed with one of the providers who told us they could not afford the transport costs.

After lunch we saw two people living with dementia wandering around the corridor unsure as to where they had to go, they had left the dining table alone and were showing signs of confusion. Staff had not recognised that these people required support and reassurance and did not respond to their requests for help.

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

The provider had a complaints procedure and we saw that the previous manager had acted upon complaints made by people or their relatives. A relative told us: "The provider is very responsive, he gave us his own personal phone number so we can contact him anytime".

Inadequate

Is the service well-led?

Our findings

Prior to this inspection we had liaised with the local authority, they had concerns about the provider's ability to maintain a service which met the needs of the people who they had placed there. They [the local authority] had spent time at the service supporting staff to make the desired improvements since our last inspection. We found that despite this support from the local authority the provider was still unable to meet people's needs in a safe way.

There was still no registered manager in post. The previous manager had left. There had been two managers since our last inspection in October 2014 and a third new manager was yet to put an application in to register. A relative told us: "There are always lots of changes in management and staff".

At our inspection in October 2014 we judged the service as Inadequate and placed it into special measures. We had checked to see if improvements had been made in April 2015 and found that although some improvements had been made the service still required further improvement. At this inspection we found that the service was once again Inadequate and the provider was not delivering care that was safe and people were at risk due to poor care delivery.

The provider's action plans they had sent us and the local authority had been ineffective as the service continued to fail to meet the required standards. Systems the provider had in place to monitor and improve the quality of service had proved ineffective. This showed an inability to improve and maintain improvement to ensure that continuous good quality care is delivered.

People who used the service were at risk due to the provider not ensuring that there were sufficient, suitably trained staff to meet people's needs. The local authority had previously highlighted with the provider the need for medication trained staff to be available at all times. There was an occasion when the district nurses had to administer people's medicines because staff were unable to. The staffing levels were not determined using a dependency tool to ensure that there were enough staff to meet the assessed needs of people. One of the providers told us: "We have always had the same amount of staff whether we are full or not".

Analyses of accidents and incidents were ineffective. We saw that the two recorded accidents which had involved the untrained member of staff who had supported a person to move with the mechanical hoist had been seen by a manager. The fact that the staff member was not trained to use the equipment had not been identified; rather it was recorded 'staff to be more careful'.

The medication audit was ineffective. It had not been identified that medicines were running out of stock, the incorrect doses of prescribed medication being administered and the times when people had not received their medicine. This had put people's health at risk.

People's care records were not accurate and up to date. Risks were not being assessed to ensure the provider was minimising risks to people's health and safety. People were at risk as care plans and risk assessments did not reflect people's current care needs. When requested by a health professional to

implement a plan for one person this had not been completed, leaving them at risk.

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

The provider had employed a consultant to support them in improving the service. The provider had previously hired a consultant in October 2014 following our inspection when the service was judged as Inadequate. This meant that despite previous external advice and support the provider was unable to maintain a service that met people's needs in safe and effective way.