

Farrington Care Homes Limited

Carlton House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	Requires Improvement ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 12 and 14 January 2016. The last inspection took place on 22 January 2014. The service was meeting the legal requirements at that time.

The service is a care home which offers care and support for up to 24 older people. At the time of the inspection there were 22 people living at the service. Some of these people were living with dementia. The service comprises of a detached building with three floors.

The service had a registered manager in post. 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.

Our key findings across all the areas we inspected were as follows:

Specifically, we found the service to be requiring improvement for providing safe and well-led services. Therefore, the overall rating is 'requires improvement'.

In addition to a medicines issue, we identified the concerns which led to a rating of requiring improvement in safe and well-led apply to the fact that although improvements had been carried out following a significant event; it was too early for the registered provider to demonstrate the service was safe and well-led. To do so, the provider must demonstrate a consistent track record of improvements. We will keep the service under review to check if the noted improvements are sustained.

We observed that prior to a significant event; people receiving care were exposed to risk of harm because some aspects of the premises were not always maintained to help keep people safe. We also noted that the quality assurance processes of the service had not identified these shortfalls. For example, the patio door alarms had been disabled for a long time despite this posing a risk to people living at the home, who were predominantly at risk of leaving the building unsupervised for their safety.

However, we also found that the service had an effective system in place for reporting and recording significant events. Following the significant event, lessons were shared to make sure action was taken to improve safety.

We found the service had made improvements to make people safe. People told us they felt safe and secure at the home. However, arrangements for medicines management were not always safe. In one instance we observed medicines for one person were not being administered according to instructions. This meant potentially this person was receiving inadequate pain relief to meet their needs.

Staff were trained in safeguarding adults and understood how to recognise and report any abuse. Care staff

understood what constituted abuse and were aware of the steps to take to protect people.

People were supported by staff who were well trained. Staff received specific training tailored to people's individual needs in addition to mandatory training.

People were supported to eat and drink sufficiently to maintain a balanced diet. People were regularly consulted about their food and drink choices and were supported to express their preferences for meals and snacks.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005. People were involved in making decisions about their care and support and their consent was sought and documented.

People told us they were treated with dignity and respect. Care staff understood the need to protect people's privacy and dignity. Staff anticipated people's care needs and attended to people in a timely manner.

People felt able to complain or raise concerns, the home supported them to do this and concerns were resolved quickly.

Systems to monitor the quality of the service had been improved.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of this report

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 always safe. The service did not always manage medicines safely and appropriately.

Following an untoward incident involving a person using the service, the service had made improvements to the safety and security of people at the home. People told us they felt safe and secure living at the home.

Staff were knowledgeable about safeguarding policies and procedures and the action required if they thought someone was at risk.

Staff told us and records confirmed they went through a robust recruitment process before they commenced employment.

Is the service effective?

Good 

The service was effective.

Staff received induction, training and supervision to support them in their roles.

People had access to healthcare services when they needed them. The registered manager and staff were proactive in referring to health care professionals.

Staff understood how to apply the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily.

Is the service caring?

Good 

The service was caring.

Relatives were happy with the care their family member received.

Staff were kind and compassionate and treated people with dignity and respect.

People were involved and their views were respected and acted on.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care which had been discussed and planned with them, including their relatives where necessary.

People were given choices and supported to take part in activities.

People knew how to complain and felt that they were able to raise any concerns and they would be listened to.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Although we found that there had been recent improvements, this was the result of actions being taken after an incident at the service. Before the incident the service had only been partially successful in auditing and improving the service.

Despite this people told us that the service was good and the registered manager was held in high regard.

Carlton 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 took place on 12 and 14 January 2016 and was carried out by two inspectors and a pharmacy inspector. It was unannounced.

We brought this inspection forward because of a significant event at the home and we wanted to make sure care provided was safe. The service notified us of an incident involving a person who was receiving care at the home. This incident is still being investigated by relevant authorities. After the incident the provider wrote to inform us of improvements they were implementing to correct any shortfalls. At this inspection, we checked whether they had followed their action plan.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

On the day of the inspection we spoke with seven people who lived at the home, a relative, a healthcare professional, the registered manager, two directors and eight members of staff. After the inspection we received feedback from four local authorities who have responsibilities of some people living at the home and a healthcare professional.

We spent time observing the interaction between people who lived at the home and staff. We also spent time looking at six care records of people who lived at the home. We looked at the recruitment, supervision and appraisal records of seven members of staff, staff training records and other records relating to the management of the home.

Is the service safe?

Our findings

People receiving care told us they felt safe and secure living at the home. One person said, "The new security system makes you feel safe". Feedback from relatives and other stakeholders confirmed they were happy about the safety of their loved ones. One person's relative told us, "My [relative] is safe and secure here". When we asked another person if they felt safe they told us, "Yes, it is safe here." Healthcare professionals also had no concerns about people's safety. A healthcare professional told us, "As far as I am concerned people are safe." We observed that people were calm, comfortable and relaxed in the presence of staff and looked to them for guidance when they were unsure.

Prior to this inspection, we received a notification related to a significant event relating to a person who used the service. At this inspection we looked at whether people were at risk of harm.

There were appropriate arrangements for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. We checked the medicines for all the people who used the service and no medicines were out of stock.

Medicines were stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. The provider did weekly audits. The stock balances for medicines not in the monitored dose system were recorded and the sample we checked was correct. Records showed staff had completed medicines management training and we saw medicines competency assessments had been completed for those staff who administered medicines.

The medicine administration records (MAR) records showed people were normally getting their medicines when they needed them. For most people there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. However for one person who was prescribed a strong painkiller, the administration was only recorded in the controlled drug register and there was no record on the MAR chart. These painkillers were prescribed to be given every 12 hours; twice a day. However records showed that they were not being administered according to these instructions. For several days it was not given at all and on others only once a day. The registered manager explained the person had complained of feeling drowsy. However, this meant potentially this person was receiving inadequate pain relief to meet their needs.

This was a breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always managed properly and in a safe way.

We also looked around the home to check how the premises were maintained to help keep people safe. We found that the service had made improvements to the safety and security of people living at the home since the significant event that was reported to us. However, prior to this event, people were at risk of harm because systems and processes were not adequate to keep them safe.

Most people who lived at the home had dementia. Their risk assessments highlighted they were 'at risk of

wandering and absconding from home due to the confusion with dementia'. However, we found that the patio door alarms had been disabled. One staff told us this had been disabled a year ago. This posed a potential risk to people at risk of wandering being able to access the garden unsupervised for their safety. The directors of the home notified us they were investigating why alarms had been disabled.

It was also reported to us that a security light at the rear garden was not working. Apart from the home not having benefits from the security viewpoint, this also posed the risk of reduced night vision for staff to see if people wandered outside into areas that were unlit.

At the time of our inspection there were 21 people living at the home; some also had dementia. We saw that the service had operated with insufficient staff to be deployed to meet people's needs during night shifts. At this inspection there were sufficient staff deployed during the morning and afternoon shifts to meet people's needs. There was the registered manager, a senior care staff, four care staff, a cook, two cleaning staff, and a laundry staff on duty. We looked at previous and future staffing rotas and saw that the service had consistently maintained this level of staffing for early shifts (8am to 2pm). The afternoon shift (2pm to 9pm) was equally staffed except they had three care staff instead of four. We saw that people used the facilities at the home, garden, communal room and the dining area and there were sufficient staff to accompany people and to stay with them. People's needs were usually met quickly. We heard bells ringing during the inspection and these were responded to promptly. We saw examples where staffing levels had been increased to support people needing extra support.

However, prior to the significant event, staffing levels were arranged to provide two care staff at night. This meant at any time there was one staff looking after people, one on each floor. There were 8 people on the ground floor and 13 on the first floor. This posed a risk that if there was an emergency there would not be sufficient staff to be deployed to meet people's needs.

However, following the significant event in December 2015, the service had made improvements to the safety and security of people living at the home. The risk assessments for the environment had been reviewed and as a result the service had taken action to minimise the risk of future occurrences of similar untoward incidents by improving their monitoring systems.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw that lessons were shared to make sure action was taken to improve safety in the service. All incidents were recorded by the registered manager and logged in an incident book. Each incident was investigated and a report was prepared by the registered manager which was cascaded and shared with the team at staff meetings. In addition, we reviewed some staff minutes which identified lessons learned. For example, regarding the stated significant event, the service had carried out an investigation and learning points had been identified and implemented.

We saw that a new alarm system had been fitted. This covered each bedroom, three lounges, toilets, bathrooms, fire doors and exit doors. This ensured staff were alerted when any door was opened and therefore improved the observations of people who needed to be monitored for their safety.

At the time of the inspection, a LED lighting system had been ordered to be placed round building to improve visibility during the night. We were notified after this inspection that the lighting system had been installed.

In addition, the senior management of the home had increased the number of night staff from two to three. Future staffing rotas showed the service planned to maintain this level of staffing at nights.

We also saw the registered manager had updated the people's needs assessments. Each person had a personal emergency evacuation plan (PEEP). This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency.

Staff demonstrated their awareness of how to keep people safe and had received training on safeguarding procedures. The safeguarding policy was in place, and this was known and understood by staff. It contained information such as how to keep people safe, how to respond to allegations or concerns, how to make a referral, and contact details of the local safeguarding team. Staff were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, or where appropriate, the local authority or the Commission. Records showed the registered manager was aware of their responsibility to report abuse allegations, and had made relevant safeguarding referrals to the local authority and the Commission where appropriate.

Care records had been reviewed and contained all relevant care plans and risk assessments. Risks to people's safety had been minimised through assessments, which identified potential risks in areas such as maintaining safety, personal hygiene, mobility, manual handling, falls, communication, swallowing and skin integrity. All risk assessments and care plans were reviewed on a monthly basis, or sooner if the person's needs had changed.

Is the service effective?

Our findings

People and their relatives were positive about how they were supported by staff. They were consistently complimentary about the attitude of the registered manager and care staff, whom they described as 'competent'. People felt confident staff had the skills to provide them with the care they needed. A person receiving care told us, "You get a distinct impression that [staff] are well trained." This view was backed up by a relative of this person. A healthcare professional told us, "Everyone values the excellent work that the manager and her team do. Their care is person centred." We observed staff assisted people with their needs in a timely and attentive way. They reassured people in distress, offered drinks and snacks throughout the day, assisted people with mobility needs and those who may have required personal care.

Training records showed that staff had received induction training prior to commencing work. The training was tailored to the specific needs of people using the service, such as management of people with swallowing difficulties, end of life care, Parkinson's and dementia awareness. Staff also attended mandatory training, including refresher sessions, to keep their skills up-to-date. This included training in Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), health and safety, moving and handling, fire safety, food safety, and infection prevention and control. Staff confirmed there was good access to training opportunities and personal development was encouraged. This demonstrated that the home ensured all staff were up to date with their training requirements.

New staff had undergone a period of induction. An induction programme was in place. New staff were working towards the Care Certificate; an identified set of standards that social care workers adhere to in their daily working life. New staff worked alongside experienced staff to help them build relationships with people and provide care in a consistent way. The induction programme enabled staff to be assessed against a variety of competencies, for the duration of their probation period. People told us that staff were knowledgeable and skilled in their role.

Staff members received individual monthly supervision sessions with their line manager and regular annual performance reviews. Staff and records confirmed this. Staff told us this gave them an opportunity to discuss any training needs or concerns they might have about their performance.

Staff supported people to maintain good health and access health services when required and when this was part of their support. Records showed the service worked closely with other health care professionals. We saw examples when the service had contacted relevant healthcare professionals to attend to people's needs. There were arrangements for on-going support for people with chronic conditions. For example, information was available from the speech and language therapist to ensure people were supported to have food and fluids safely; management of hypoglycaemia; what staff were required to do when blood sugar levels of identified people fell too low. A healthcare professional told us, "We have encouraged patients to use Carlton House and I would be happy for members of my family to go there."

People were supported by staff who had a good understanding of the Mental Capacity Act 2005 (MCA). The 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 decision made on their behalf must be in their best interests and as least restrictive as possible.

There was evidence the registered manager had considered people's capacity when consent was needed. For instance, when medicines were being administered covertly to people we saw there were appropriate agreements in place which had been signed by the GP, family and pharmacist. The registered manager had completed the necessary assessment to ascertain the person's capacity to make the decision about a treatment that they required. Following the assessment the registered manager had taken appropriate action to ensure the decision taken was in the best interest of the person.

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). We checked whether the service was working within the principles of the MCA. The registered manager had taken action around this and had submitted applications to the local authority for deprivation of liberty safeguards to be put in place where necessary. The registered manager told us people who they had assessed as requiring constant supervision, who were prevented from leaving the service if they attempted to do so had been referred to the local authority. At the time of inspection seven DoLS authorisations were in place.

Training records showed that staff had received training on DoLS and the MCA. Staff were clear on the process for DoLS and mental capacity assessments.

Staff supported people to maintain a balanced diet appropriate to their dietary needs and preferences. We observed the lunch time period in the dining area. During the inspection it was clear that individual meals were made for each person at their request. There was information displayed in the kitchen, which listed dietary requirements for people. This included people on sugar free diet and those who required their food to be fortified. We spoke with the cook who was knowledgeable about people's individual needs and likes and dislikes. The cook met with people in order to identify their dietary requirements and preferences. The cook told us there was always an alternative on offer. During this inspection, we observed three different dishes were served according to people's preferences. People could eat in the dining room or be supported to eat in the communal lounge or their bedroom.

Is the service caring?

Our findings

People told us the registered manager and staff were kind, considerate, and caring. They told us staff gave them time and listened to them. For example, one person told us, "All staff are caring", and another said, "The manager is fair. She treats all the people in the same way."

There was a homely, warm and friendly atmosphere. People were consistently positive about the care and support people received. We observed people were relaxed and engaged with the staff, who, involved them in various activities around the home.

Staff were knowledgeable of the people they looked after and were able to identify early indications that they may be becoming unwell and may need to be assessed by relevant healthcare professionals. We saw examples where people were referred for assessments, which demonstrated staff were able to identify when someone may require additional support. We spoke with a healthcare professional who told us, "The manager and her team are very caring and compassionate."

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering. During lunchtime we observed staff positioned themselves to people's eye level to talk with them and encouraging them to eat.

People were involved in their day to day care. This included arrangements for their information to be shared with visiting health care professionals when necessary, according to Data Protection Act 1998 requirements. People's care plans and risk assessments were reviewed regularly and people and their relatives were involved. This was to ensure they remained appropriate to people's needs and requirements so staff understood when people may need more support and attention.

People and their families were involved in decisions about their care and the running of the service. There were regular 'residents meeting', where people and their families had discussed activities, menus and other relevant issues pertaining to the improvements at the home.

People's end of life wishes were recorded in their care plans when they came to the service. People had end of life care plans in place. Staff discussed with people their preferred place for end of life care and this had been recorded in their care plans. The district nurses supported staff when people were nearing the end of their life. Written feedback received from a health care professional read, "The Home work with us to manage even the frailest patients, especially around End of Life Care."

Is the service responsive?

Our findings

People who wished to move into the service had their needs assessed, prior to moving in, to help ensure the service was able to meet their needs and expectations. The registered manager and senior staff carried out the initial assessment of people who had been referred to the service. The registered manager told us this was to ensure they met the needs of people appropriately before they could be admitted to the service. A relative confirmed they had been involved in writing care plans and felt their opinions were well considered. A compliment from another relative of a person receiving care read, "It took little time for my [relative] to settle and that was mainly due to the staff and [the manager] making my relative feel at home and prioritising their needs." People told us the service was responsive to their needs. One person said "All is just as you would want in your own home."

Care plans were personalised to the individual and gave details about each person's specific needs and how they liked to be supported. These were reviewed monthly or as people's needs changed. Care plans provided guidance for staff to follow to meet people's needs and wishes. The care plans identified specific areas of need and goals, including nutrition, mobility, communication, medical history, personal safety and activities. The registered manager and staff were knowledgeable about people's needs.

The service responded to people's changing needs. For example, the registered manager had analysed falls and their frequency. Her analysis had suggested an association between certain type of medicines and the frequency of falls. On this observation she referred some people to the mental health team. In one example, we saw that the medicine for this person was changed and there was a decrease in the number of falls. In another example, the medicine of one person was changed owing to the negative effect it had on their behaviour. A healthcare professional who had visited this person spoke with pride about the way this person had responded to the new medicine. The healthcare professional told us, "The manager and staff always implement our recommendations. The manager is up to the task. They are doing their job well."

People were able to take part in activities of their choice. There was an activity planner, which set out people's preferred social and leisure activities. Staff supported people to access the community. Activities included, fortnightly sing along sessions, which the manager said were used for reminiscence for people with dementia; religious services, outings, one to one activities and ball games. In a survey that was carried out on visiting healthcare and social care professionals, they had indicated that they 'agreed that residents were encouraged to get involved in recreational activities'.

There was a complaints procedure in place. The procedure gave details of who people could speak with if they had any concerns and what to do if they were unhappy with the response. People using the service and their relatives told us they were aware of the complaints procedure or who to contact if they had concerns. They consistently told us that they did not have any concerns. However, they were aware they could raise any issues with staff and felt confident these would be addressed.

Is the service well-led?

Our findings

People receiving care, their relatives, staff and visiting healthcare professionals told us the service was well managed and the registered manager was open and approachable. Their comments about the registered manager were consistently complimentary. They included, "The manager is always available", "The manager is very supportive and listens to us" and "She is a very good leader. She brings staff with her. She does not drive them."

We checked the governance arrangements which supported the delivery of quality care. From records prior to the incident, we saw that there was a clear staffing structure and staff were aware of their own roles and responsibilities. There was a programme of internal and external audit which was used to monitor quality and to make improvements. In addition, there were arrangements for identifying, recording and managing risks and implementing mitigating actions.

However, following a significant event, it became apparent that these arrangements were not always effective at identifying shortfalls in the service. For example, an audit that was carried out in August 2015 had identified that the service required improvement for providing safe and effective services. However, the audit was only partially effective in that it missed other shortfalls such as in the security system of the home or the question of whether two staff at night was a sufficient number to care for the people using the service.

Following the significant event, we saw that the service had made improvements to their governance systems.

A new alarm system had been installed. This enabled the management to monitor the support people received during the night. It automatically recorded when night staff completed scheduled monitoring visits to people's rooms. We saw from records how this was used to monitor if staff were completing scheduled hourly visits to people's rooms as stated in people's risk assessments.

Following the incident, arrangements were also put in place for the deputy manager to carry out random night inspections to ensure people were safe and being checked at stated times. We saw from records that these checks were being carried out.

All this meant the service had improved control measures to reduce risks to people and the likelihood of incidents reoccurring. However, it had taken a significant event for these improvements to be carried out. Therefore, the Commission will be monitoring all the above improvements and also to verify if they are sustained.

The provider had complied with the requirements of the Duty of Candour. Following a significant incident, the service held a meeting with people and their relatives to disclose the incident and also to share information about the changes they were implementing to improve people's safety and security.

At this inspection we also observed there was a clear leadership structure in place and staff felt supported

by management. Staff told us and we saw from records that the service held regular team meetings. Staff told us that there was an open culture within the service and they could raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported by the registered manager.

The registered manager encouraged all members of staff to identify opportunities to improve the service. Topics relevant to practice were also discussed during meetings. These included, safeguarding, MCA 2005 and DoLS, Equality Act, nutrition, privacy and dignity, pressure care and night care, including checking people who were on observations regularly. This showed how the service used staff meeting to ensure staff were always up to date with best practice and research.

The service encouraged and valued feedback from people, their relatives and other stakeholders. It proactively sought their feedback and engaged them in the delivery of care. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always follow policies and procedures to ensure the proper and safe management of medicines.