R G Care Ltd

The Farmhouse

Inspection report

272 Wingletye Lane
Hornchurch
Essex
RM11 3BL

Tel: 01708620949

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09 September 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
The Farmhouse is a residential care home providing personal care for up to maximum of 7 people. The service provides support to people with a learning disability and autistic people. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
The service could not show how they met some principles of right support, right care, right culture.

The provider was not always assessing, monitoring and improving the quality and safety of the service. We found risks to people were not being mitigated effectively which could lead to people being harmed. For example, windows restrictor were not fitted properly to prevent people climbing out of them and putting themselves at risk.

Pre-admission assessments and care plans were not robust to ensure people's preferences with support and care were captured. Care plans lacked evidence that people were being involved in decisions about their care.

Medicines were not always managed safely and effectively. Staff did not always record temperatures where medicines were stored. The covert administration of medicine was not being managed in line with the provider's own policy.

Agency staff were not always being given appropriate training to understand people's care needs. People's care plans contained conflicting and confusing information about their wheelchair assessment. Where decisions were made in their best interest by professionals or the person's representatives, such as relatives, there were no records of this for all the care plans we looked at.

We were not assured there were enough staff to meet people's needs. We also looked at four-week staff rota. The staff rota confirmed on average every weekend there were 10 agency staff being deployed at The Farmhouse. This resulted in people not being supported or able to take part in activities and visits how and when they wanted.

Supervisions meetings with staff were inconsistent, staff were not always given opportunities to discuss their progress or discuss issues.

The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. Accidents and incidents were recorded but not monitored to identify how the risks of reoccurrence could be minimised in future. The provider had failed to notify the Care Quality Commission of all reportable incidents as required. Providers are required to notify the CQC of certain incidents without delay.

Right support
Risk assessments were not always followed to make sure people were safe. Medicines were not always managed safely and people's abilities in managing their own medicines had not been routinely assessed. Environmental risks were not always identified and addressed through audit systems. Staff were not recruited safely and there were not always enough staff to meet people's needs and maintain a clean and safe environment for people. We also found care records were unclear in relation to people's capacity and there were inconsistencies in the 'best interest decision' process.

Right Care
People were not fully supported to meet their social and recreational needs. Staff knew people well but there were missed opportunities to fully involve people in their care and to promote people's independence.

Right Culture:
There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service. Shortfalls across the service such as poor risk management, lack of oversight of staffing and supervision and limited oversight of people mental capacity had not been identified prior to our inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 05 June 2022) and there were four breaches of regulation specifically on Regulations 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment), Regulation 17 (Good governance), and Regulation 18 (Staffing). At this inspection, not enough improvement had been made, the provider continued to be in breach of regulations 12, 13, 17 and 18 for the second time.

Why we inspected
The inspection was prompted in part by notification of a specific incident following which a person using the service sustained a serious harm. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook this inspection to check if there were improvements regarding the concerns we identified at the last inspection and if the service was compliant with the requirement notices on Regulation 13, and

warning notices we served on Regulation 12, 18 and 17.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection.

You can read the report from our last inspection report, by selecting the 'all reports' link for The Farmhouse on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relations to safe care and treatment, good governance, staffing, need for consent, person-centred care, privacy and dignity, premises and maintenance, Safeguarding service users from abuse and improper treatment, and Fit and proper persons employed.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our well-led findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our well-led findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our well-led findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our well-led findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

The Farmhouse

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors, 1 medicine's inspector, 1 senior specialist advisor, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Farmhouse is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Farmhouse is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, the registered manager was on leave. We were supported by the area manager, site manager and deputy manager, who was a representative of the provider and was managing the service.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 06 September 2023 and ended on 09 September 2023. We visited the location on 06 and 09 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 4 people's care records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, incidents and accidents were reviewed. We reviewed 4 medicine administration records. We spoke with 8 members of staff including the area manager, site manager, deputy manager, 2 support workers and 4 agency staff. We were able to get limited views from people only due to their needs.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We continued to seek clarification from the provider to validate evidence found.

We looked at care records, staff training records and policies and procedures. After the inspection, we spoke with 5 relatives by telephone about their experience of the care provided.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection, the provider failed to put in place clear and comprehensive risk assessments for people to minimise potential risks to their health and safety. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the service continues was compliant with the warning notice we served at the last inspection.

- Risks to people's safety were not mitigated against effectively to prevent people coming to harm.
- One person skin integrity risk assessment said staff should do a full body check every morning to identify any marks. We asked the site manager to provide us hardcopy of body maps, we been told the resident has ripped all the document. There was no risk assessment or guidance in place regarding how to mitigate the risks associated with their medical conditions. This meant this person was being placed at risk of harm because the risks associated with their care had not been adequately assessed and managed.
- In another person's care plan, we looked at their wheelchair assessment which mentioned, 'I get tired of walking long distances and will sit on the floor and refuse to get up if I don't want to walk anymore.' In other section of their care plan, it was mentioned, 'However I should not be encouraged to be in the wheelchair for the entire time as I can walk and should not become dependent on my wheelchair in the community.' The care plan contained conflicting and confusing information about their wheelchair assessment. This meant this person was at risk of a potential for a serious incident.
- We saw from records that one person had sustained a head injury in May 2023. The person received treatment from external health professionals. The person's risk assessment had not been updated to reflect a change to their needs. It did not contain guidance for staff on how to support the person safely and the action they needed to take if the wound opened. There was no information in relation to lessons learnt. This meant this person was being placed at risk of harm because the risks associated with their care had not been adequately assessed and managed.
- We reviewed the record of one person who had fall and sustained a fracture on their lumbar. The record of the accident stated they had sustained a serious injury. Staff called the paramedics and was taken to a hospital; this person's risk assessment had not been reviewed or updated following the fall to establish whether there had been a change in their needs. This person's care record did not contain guidance for staff on how to support them safely following the injury. This meant this person was being placed at risk of harm because the risks associated with their care had not been adequately assessed and managed.
- These failures evidenced a lack of learning from events or action taken to improve safety, placing people at risk of harm.

● Our inspection of the premises included looking at windows and how they were secured. We found one bedroom the window restrictor was not fully secured. Window restrictors are used to restrict how far a window can be opened to prevent the risk of people climbing or falling out of them, which could lead to serious injury or death. This meant there was a high risk of the person coming to avoidable harm should they access one of the windows.
● These failures evidence a lack of learning from events or action taken to improve safety, placing people at risk of harm.
● There were records of checks on systems such as water, gas and electrics to ensure the building was safe. People had personal evacuation plans in the event of a fire or other emergency.
● One relative told us, "When l visit I feel that my loved one is secure."

Using medicines safely
● Medicines were not managed safely and effectively.
● Staff did not always record temperatures where medicines were stored. To ensure their efficacy, medicines need to be stored in an environment where temperatures can be maintained within an appropriate range. Fridge temperatures where medicines are stored need to be checked regularly and appropriate action taken when temperatures fall outside of the acceptable range. Whilst staff recorded current fridge temperatures, they did not record minimum and maximum fridge temperatures This meant the provider was unable to assure that those medicines would be safe and effective to use.
●Where it had been assessed that people needed to receive their medicines covertly, staff viewed this as a last resort and always offered a person their medicines covertly in the first instance.
● Some service users needed to receive their medicines covertly. The provider had a policy and procedure in place to manage this. We saw one person had been identified in their care records as requiring covert medication if they refused prescribed medicines when offered to them. For this person, we did not see clear guidance for staff on how to covertly administer each of the medicines they were prescribed. This meant we could not be assured that all staff had clear guidance on how and when they should safely and appropriately administer medicines covertly.
● In addition to this person's care records detailed a meeting involving family and healthcare professionals (a best interests meeting) addressing the need for covert medication had last taken place in 2019. The provider medication policy stated, 'If the authorisation is longer than 6 months', monthly reviews of the covert medication, involving family and healthcare professionals must be carried out and recorded.' These monthly reviews had not taken place. This meant the provider and registered manager had failed to follow and implement their own medication policy in relation to covert medicines.
● Staff conducted monthly medicines audits; however, they were ineffective in providing assurance of safe medicines use. None of the medicines concerns highlighted during this inspection had been identified.

We found that systems were not always in place to effectively assess and managed risks to people while they receive a service. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism, or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● Staff ensured that all the people living in the service had received annual medication reviews as per government guidance.

Staffing and recruitment

● Records showed pre-employment checks had not been completed in full. Checks had been made such as on criminal record and obtaining proof of staff's identity.
● The provider's recruitment policy stated that two professional references should be sought prior to employing staff. We found for one staff, only one employment references which was not in their job application had been requested, and the other reference had not been requested. This meant there was a risk the service may not get an accurate picture of staff character and conduct.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe recruitment. This placed people at the risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, the provider relied heavily on agency staff, especially for waking night. We were informed some staff had left recently and this affected the number of permanent staff. To mitigate this, the provider told us that they used staff from one agency.
● Not enough improvement has been made at this inspection. The provider is still relying on agency staff, especially for waking night and weekends. Staff told us there were not enough staff to provide people with appropriate personal care, such as showers, accessing the toilet on a regular basis, and people had to wait for staff to provide care.
● Staff consistently told us there was not enough staff. One staff member said, "Yes, we do need more permanent staff, when there is an agency staff we have to come in our off days and support residents with their medicines." We also spoke to a member of staff and told us the cleaning staff are on leave and they had to clean the home for the next few days, otherwise the home would become unhygienic. The lack of staff placed service users them at risk of harm.
● We looked at a four-week staff rota for August 2023. This showed that on average, over each weekend, out of 23 allocated shifts, there were 18 agency staff and 5 permanent staff being deployed on duty. That meant on each shift 70% of staff were agency. High use of temporary agency staff meant that service users were at risk of receiving inconsistent care from staff that were not familiar with their needs or preferences.
● We reviewed the personnel records for one permanent staff member. Their records showed that they had received a verbal warning from the registered manager. There was no investigation report or record in supervision meetings to indicate why they had received a verbal warning.
● We looked at the providers staff investigation policy, this stated, 'The investigating officer must gather all facts before determining what the recommendations may be, a full report with summary of the findings must be completed and given to the disciplinary manager.' We found that the registered manager had failed to follow and implement the provider policy in relation to permanent staff member when instigating disciplinary procedures that had resulted in a verbal warning.

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us that 10 staff had been recruited and were undergoing pre-employment checks prior to starting their employment.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, people were not always safeguarded from the risk of harm because the provider did not implement procedures to keep them safe. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the service continues to be in breach of regulation 13.

● At our last inspection, people were not always safeguarded from the risk of abuse. One person's care showed the person needed 2-to-1 staff support with personal care. The registered manager told us that because of the size of the bathroom, only 1 care staff was able to provide personal care to the person. However, at this inspection we saw the person has a new bathroom, where the person was able to receive 2-to-1 staff support with personal care.
● At this inspection, we found improvement was still needed with regards to safeguarding incidents that had occurred. Although a safeguarding log was in place, it did not always contain the information related to the investigation completed by the local authority. This meant we could not be assured of lessons learnt by the provider.
● The provider Adult Safeguarding policy states, "The Registered Manager or delegated person sends a statutory notification to CQC concerning any abuse or alleged abuse involving a person(s) using our service. This includes where the person(s) is either the victim(s) or the abuser(s), or both." The provider failed to ensure that registered manager and staff recognised and reported abuse. Staff had not reported safeguarding incidents. An incident took place on 24 May 2023. It was recorded that this person had a fall and sustain a head injury. This person received treatment from external health professionals. The provider failed to recognise abuse. While local authority was aware of this incident, Care Quality Commission were not notified about this serious injury.

The systems for safeguarding people from abuse were not operated effectively. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had undertaken training about safeguarding and understood their responsibilities about it. One staff member said, "I would stop the incident. I will then speak to the lead worker. I will contact the director."
● The provider had a whistleblowing policy, which guided staff on how they could raise concerns about any unsafe practice.

Preventing and controlling infection
● The fridge had food which was not stored properly. The fridge was being used by staff and residents at The Farmhouse. Several food items were opened and had not been appropriately sealed. There was no date of when the food was opened or should be used by. The provider could not be assured that appropriate food hygiene measures were in place to minimise the spread of infection and contamination.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We recommend that the provider follows best practice in infection control.

Visiting in care homes
● Visitors were allowed to visit their loved ones whenever they wanted. There were no restrictions on visitors.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At our last inspection, the provider had not ensured that staff received the appropriate training to undertake their roles effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the service continues was compliant with the warning notice we served at the last inspection.

● At our last inspection staff had not completed a number of essential training programmes, for example epilepsy, challenging behaviour and communication to enable them to undertake their roles effectively. At this inspection improvement was still needed.
● At this inspection, agency staff who were working regularly at the service had not received training to enable them to safely support people. 2 staff had been working at The Farmhouse for between 6 and 9 months. The Farmhouse training matrix and staff rota for 2023 showed agency staff did not complete trainings such as learning disability awareness and managing challenging behaviour. Therefore, the provider could not be assured all agency staff had the skills and required training to appropriately meet service users needs on each shift.
● We were not assured regular agency staff working with people were appropriately trained and supported to effectively care for people.
● Staff did not receive support from the registered manager. Staff did not receive support in the form of continual supervision, appraisal and recognition of good practice. Supervisions were not taking place regularly.
● We reviewed 3 staff supervision meeting records. 1 staff who has been working at The Farmhouse over a year, had not receive any supervision meeting during that period. Another staff member had not received an annual appraisal.
● The provider had a supervision policy stated staff should receive supervision a "Minimum of four times per year, as well as an annual appraisal meeting." Supervision of staff was not taking place in line with your policy. Without this form of support and without competency assessments we were not assured staff were meeting the requirements of their role and were adequately supported.
● The above issues meant that we could not be assured that staff received the appropriate support and supervision from the provider to enable them to carry out the duties they were employed to perform.

The provider did not ensure that staff received the appropriate support, supervision and appraisal as

necessary to enable them to carry out their duties. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A relative told us a permanent staff knows their family member really well, they said, "[Staff name] is an angel on earth. She knows [family member] really well and understand [family member] needs."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed in line with guidance.
● CQC would expect providers of services for people with a learning disability and on the autistic people to demonstrate how they are complying with the principles of right support, right care, right culture guidance.
● We were reviewed one person care pre-admission and these were not assessed prior to admission. The provider did not have robust assessments in place to ensure that the service could meet the needs of people prior to offering to care for them at their service. This person care record had insufficient information from previous provider, for example, there was no information on how to safely de-escalate challenging behaviour. In addition, this person did not have a timescales or objectives to meet their needs. This person care records did not give any idea of what is their routine, or who at The Farmhouse this resident enjoyed being with; of activities this person gained the most joy from; of the times this resident enjoyed getting up, going to bed or what this resident enjoyed eating. This meant people were at risk of receiving care from staff who did not fully understand their health conditions or preferences in how care was delivered.
● We spoke with the deputy manager and lead key worker who stated they would discuss new referrals that they had received from the referring agencies with staff, before deciding whether they could be admitted. One of the staff we spoke with said, "The registered manager did not involve us in the transition of this new person."
● There was a risk that people's needs were not being assessed correctly. The above shows that the provider had not always carried out, collaboratively, with the relevant person an assessment of people's needs and preferences, to confirm they would be able to provider person-centred care to them according to their needs and preferences.

The provider and registered manager had failed to carry out, collaboratively with the relevant person, an assessment of each service user's needs and preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where decisions were made in their best interest by professionals or the person's representatives, such as relatives, there were no records of this for all the care plans we looked at. There was no evidence to show who attended the meeting and the date of the meeting. If people had provided verbal consent because they were unable to sign their care plan, this was not documented.
● We fed this back to the provider, who informed that they were aware of the issues as it was identified during audits and were addressing this.

Failure to take into account people's capacity, ability to consent and ensure decisions were made by those who have legal authority to do so is a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training on the Mental Capacity Act which covered obtaining people's consent prior to delivering any care and the principles of the MCA. One staff member said, "Yes, we speak to our resident and tell them before we do any personal care."

Adapting service, design, decoration to meet people's needs
● We found issues of concern with the physical environment of the service. We found one of the bathrooms did not have any hand towels. Our inspector spoke to a member of staff and told us the cleaning staff are on leave and they had to clean the home for the next few days, otherwise the home would become unhygienic.
● We also found the sluice and storage room were always unlocked. This meant people were at risk of a potential for a very serious incident.
● Food menus were displayed in a small written text, despite there being some people living there who can't read.

We recommend that the provider follows best practice and improves the environment of the service.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink to maintain their health and nutrition. We observed people having lunch and saw, people were assisted to eat and drink where required.
● Care plans recorded people's dietary needs and preferences. This information was shared with staff, so they knew whether people had allergies or religious restrictions with food. There were records of interaction with healthcare professionals regarding food and fluids, directing how staff could best support people in this regard.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported with their healthcare needs. Care plans and risk assessment contained information relating to different medical needs, and people's health and wellbeing were regularly assessed.
● One person had complex health concerns and received support from a range of health care professionals. The provider maintained communication with these professionals where required and followed their instruction where necessary.
● The service recorded relevant information about people's care in daily notes. Staff could access these notes and this assisted in providing effective and timely care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● People were not always treated with kindness and compassion. The high numbers of agency staff at The Farmhouse meant although the numbers of staff available may appear sufficient, the deployment of staff who knew people well impacted on the care received.
● We used our short observational framework inspection [SOFI] tool, to assess staff engagement with people. During our observations, staff did not consistently engage people who had no or limited verbal communication. For example, we saw two staff sitting outside in the garden with one resident and there was no interaction. Another staff sitting next to the swings with a resident, again there was no interaction as this staff was on their mobile phone. These practices did not ensure people were cared for and supported.
● Some staff did not engage or smile at people whilst serving meals. A person who was sat alone in their bedroom was provided with assistance to eat their lunch. However, the staff member supporting them failed to engage in conversation with them.
● Staff told us they gave people choices about their support and involved them in all decisions about their care and lives. They said they gave people information to make informed choices and respected the decisions people made. However, we noted that care plans did not always reflect this or contain information relevant to the person and were not individualised to reflect people's needs. A positive person-centred culture was not promoted which took account of people' views and preferences and promoted good outcomes for them.

The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Notwithstanding the above, families told us people were treated with kindness and respect. One relative commented, "They always listen to [family member] needs and extra attention is met."
● People's religion and ethnicity had been recorded on their care plans. People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual orientation and all people were treated equally.
● Staff understood the importance of helping to maintain people's privacy and dignity. They provided

examples of when they did this which included when supporting people with washing, dressing and continence care.

● Staff ensured people's confidentiality was maintained. Personal information was stored securely and only accessed by authorised staff. Information was protected in line with General Data Protection Regulations (GDPR).

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Care plans were not generally written with a person-centred approach, they lacked evidence of the involvement of the person and did not reflect people's goals, aspirations or future plans. Care plans for people with a learning disability did not always reflect the principles of right support, right care, right culture.
● We looked at 1 care plan and found they were not always personalised to include people's preferences, wishes, needs in key areas such as life history, personal care, nutrition and hydration. For example, care plan did not give any idea of this person routine; of who in the house the person enjoyed being with; of activities the person gained the most joy from; of the times the person enjoyed getting up, going to bed or what the person enjoyed eating. This meant that staff reading the care records would not have the guidance or instructions to provide people with person-centred care.
● Some people's care plans contained conflicting information. One person's care plan says, '[Person cannot be allowed in the kitchen as they lack awareness of the danger in their environment.' The same person's care plan detailed that the person should, 'Follow my lead, If it's safe to do so take me into the kitchen, support me to go for a walk.' Staff did not have clear guidance about how to provide personalised, safe and effective care.
● Staff did not always use person-centred approaches. We observed staff supporting people with meals, on several occasions this was task focused and there was a lack of communication with the person about their meal or opportunity for the person to engage and make choices. Care plans did not always include consideration of people's goals or aspirations and as a result missed potential opportunities for people to develop their interests and increase their independence.
● There was little in the way of activities in the home at the time of our inspection. We observed people sitting down for most of the day.
● The service was going through a period of difficulty as there is low number of permanent staff, meaning there was an increase in the use of agency staff to support people. Not all staff knew people well enough to be able to support them out in the community.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff did not always follow guidance in people's communication plans. Plans generally reflected people's needs and included communication assessments detailing how people communicated including actions they may take when happy or upset. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. We observed people attempting to communicate with staff, we saw, one person sitting outside in the garden and looked at the staff member. The staff member did not respond. This person was making noise with their mouth, again the staff member did not respond. The failure of staff to understand this person's communication sooner could potentially agitate their behaviour.
● One person's care plan says, 'I have no means of communication.' During our observation we saw this person to touch, vocalise, bounce, jump and push staff's hand, all of which are communication. Staff did not have clear guidance on how to communicate with residents at The Farmhouse.
● People did not receive information in a format they could understand. For example, activities timetables and food menus were being displayed in a written format, there were no posters or signage being displayed.
● Picture cards were available for people if needed, to assist them to make choices for meals. However, this was not used during our inspection. This meant the service did not seek to support people with communication needs to make choices about things they wanted to do.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and process in place which was available to people, relatives and visitors. We reviewed complaints records and could see these were investigated and responded to appropriately.
● Relatives felt able to raise concerns if needed. One relative said, "I phone straightaway and express my concern, so far it has always been settled."

End of life care and support
● At the time of the inspection no one living in the service was receiving end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

At our last inspection the provider had failed to ensure robust audit systems were in place to identify shortfalls and take prompt action to ensure people received safe person-centred care at all times. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the service was not compliant with the warning notice we served at the last inspection.

- At this inspection, we found not enough improvement had been made in relation to this regulation and the provider remained in breach.
- Robust systems to review or audit care plans, risk assessments, pre-admission assessments and medicines management were not in place. The provider failed to identify the shortfalls we found in those records. This meant you had not established and was operating effective systems that assessed, monitored and improved the quality and safety of services provided.
- The provider and registered manager had not followed their own procedures and had not always ensured that prior to people's admission to the service their needs were comprehensively assessed to ensure that the service would be able to meet the needs of the individual according to their choices and preferences.
- Care plans, mental capacity assessments and risk assessments lacked information. Where they were in place, they did not reflect the care and support people required. Risks identified, contained insufficient information to guide staff on how to manage these. The lack of information put people at risk of receiving inconsistent care and support. Although the provider had identified some of these areas for improvement, they had not identified all the failings we found. They had not ensured improvements were made in a timely way. This was important to reduce the ongoing risks to people.
- The registered manager had delegated checks to other staff but had not checked these were done correctly and actions where taken to address any shortfalls. Medication audits were completed by a senior carer. Action had not been taken to address the shortfalls found in medicines practice and these continued.
- The provider and registered manager had failed to ensure regular agency staff were adequately trained and supported. Training matrix showed agency staff had not been trained in disability awareness and behavioural challenges. This meant you have failed to ensure there were sufficient quality assurance and governance procedures to ensure staff were trained in essential areas to perform their roles effectively.

● When incidents or accidents happened, electronic records were made by staff on the provider's care records system. However, the records made were not sufficiently detailed and were not consistently reviewed by the management team. When they had been reviewed, there was no detail to describe if action had been taken to reduce the likelihood of the incident reoccurring or to identify if there were any patterns or themes.
● The provider adult safeguarding policy defines incidents as, "In the past, there have been instances where the withholding of information has prevented organisations from being fully able to understand what "went wrong" and so has hindered them from identifying to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening, they must act upon that knowledge, not wait to be asked for information." Incidents were not recorded or analysed and did not include lessons learnt to inform practice development.
● An incident took place on 11 August 2023. It was recorded that this resident had a fall and sustain a fracture on their lumbar. This person received treatment from external health professionals. There was no information in relation to lessons learnt. Therefore, systems to prevent abuse of this person had not been effectively operated.
● The provider failed to follow their medication policy. As mentioned in the safe key question, the medication policy stated, 'If the authorisation is longer than 6 months', monthly reviews of the covert medication, involving family and healthcare professionals must be carried out and recorded.' This meant the provider and registered manager had failed to follow and implement their own medication policy in relation to covert medicines.
● During our inspection, we found at times some records we requested were not easily accessible. For example, we requested one person's covert medicine guidance, another person's pre-admission form, and staff training certificates for epilepsy, moving and handling and learning disabilities, however these records were not available. Record keeping plays a fundamental part in providing high quality health care. For example, not recording the people health conditions and risks could potentially leave staff unaware of what actions staff should take.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider and registered manager had failed to ensure staff were being supported at all times through regular supervisions. The supervision policy showed that a number of staff required supervisions and had not received regular supervisions. This meant you have failed to ensure there were sufficient quality assurance and governance procedures to ensure staff and the registered manager was supported at all times.
● The provider and registered manager was not clear on how to monitor or understand quality performance at the service. For example, they had not recognised concerns we identified in relation to poor recruitment practices and there was a failure to ensure staff received a thorough supervision and an annual appraisal meeting.
● Staff views regarding the support they received from the registered manager varied. Some staff felt the provider was approachable and listened to their concerns. Others described a lack of support and an authoritarian approach.
● The provider failed to follow their Adult Safeguarding Policy. As mentioned in the safe key question, the provider and registered manager had failed to ensure that managers and staff recognised and reported abuse. The registered manager did not always identify when incidents met the notification threshold. We are concerned they did not understand their regulatory responsibilities.
● The registered manager had been in post since December 2021. They were supported by a deputy

manager, area manager and site manager. The registered manager was not present during our inspection. The deputy manager and site manager were unable to answer some of our questions. Robust systems were not in place to ensure the provider had access to important information at all times.

● We found multiple shortfalls and breaches of regulation throughout the service which put people at risk. The provider failed to identify these shortfalls.

● We were not fully assured the provider had effective systems to provide safe care. We found registered manager were not analysing and reviewing all safeguarding incidents to prevent reoccurrence.

The system in place did not ensure the safety or quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff meetings were held to share information. The meetings kept staff updated with any changes in the service and allowed them to discuss any issues or areas for improvement as a team.

● People's beliefs and backgrounds were recorded and staff were aware of how to support people considering their equality characteristics.

● The service obtained feedback from staff and relatives about the service through telephone monitoring.

● The service worked closely with healthcare professionals such as speech and language therapists, learning disability teams and psychologists to maintain and improve people's wellbeing. People were also supported to access routine healthcare in a timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure service users received person-centred care that met their needs and reflected their preferences. Regulation (1) (2) (3) (b) (c) (d)(e) (f) (g) (i)

The enforcement action we took:

We served requirement notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure service users consented to the decisions made about their care and treatment. Regulation 11(1) (3)

The enforcement action we took:

We served requirement notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure people kept safe from abuse.

	Regulation 13 (3) (1) (2)

The enforcement action we took:

We served requirement notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensure that staff were recruited following safe recruitment practices. Regulation 19 (1)(a)

The enforcement action we took:

We served requirement notice