Care Quality Commission

Mrs Sandra Christine Gold and Ronald Herbert Gold

Little Eastbrook Farm

Inspection report

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Date of inspection visit: 28 April 2015
Date of publication: 02/06/2015

Ratings

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

Overall summary

This announced inspection took place on 28 April 2015. The provider was given 24 hours' notice because the location was a small care home for adults who may be out during the day; we needed to be sure that someone would be in.

At our previous inspection carried out on 18 November 2013 we found there was insufficient detail contained in people's risk assessments and personal care records to ensure their safety. We found that improvements had been made to these records when we visited on this occasion.

Little Eastbrook Farm is a small rural care home. The care home offers accommodation and 24 hour care for up to three people with learning disabilities. People living at the home share the accommodation with the providers, and a relative of the providers.

When we visited there was 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.

Summary of findings

The home did not have a system in place to ensure accurate stock levels and medicines remained in date and the medicines cupboard did not conform with the Medicines Act 1968. In addition, both staff training and the medicines policy and procedure were last updated in 2004. This posed a risk that medicines management did not reflect current legislation and guidance.

Staff could not demonstrate a comprehensive understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and how they applied it to their practice, despite training completed on both subjects in March 2015. For example, staff did not think the Mental Capacity Act (2005) and DoLS applied to people with learning disabilities. We found the service did not meet the requirements of the Mental Capacity Act (2005).

The provider did not have systems and processes, such as regular audits and up to date and relevant policies and procedures in place to assess, monitor and improve the quality and safety of the service.

Staff received informal supervision on an on-going and informal basis due to the size of the service and team. There was no formal way of recording these sessions which would help recognise personal and professional development for staff.

People felt safe and staff were able to demonstrate an understanding of what constituted abuse and how to report concerns. Risk management was important to ensure people's safety.

People received personalised care and support specific to their needs and preferences. Health and social care professionals were regularly involved in people's care to ensure they received the right care and treatment.

Staff relationships with people were caring and supportive. Through our observations and discussions, we found the staff were motivated and inspired to offer care that was kind and compassionate.

Staffing arrangements, which included recruitment, were flexible to meet people's individual needs.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

One aspect of the service was not safe.

The home did not have a system in place to ensure accurate stock levels and medicines remained in date and the medicines cupboard did not conform with the Medicines Act 1968. In addition, both staff training and the medicines policy and procedure were last updated in 2004. This posed a risk that medicines management did not reflect current legislation and guidance.

People felt safe and staff were able to demonstrate an understanding of what constituted abuse and how to report if concerns were raised. Risk management was important to ensure people's safety.

Staffing arrangements, which included recruitment were flexible to meet people's individual needs.

Is the service effective?

Requires improvement

Aspects of the service were not effective.

Staff could not demonstrate a comprehensive understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and how they applied it to their practice, despite training completed on both subjects in March 2015. For example, staff did not think the Mental Capacity Act (2005) and DoLS applied to people with learning disabilities. We found the service did not meet the requirements of the Mental Capacity Act (2005).

Staff received informal supervision on an on-going and informal basis due to the size of the service and team. There was no formal way of recording these sessions which would help recognise personal and professional development.

People were supported to maintain a balanced diet.

There was evidence of health and social care professional involvement in people's care on an on-going and timely basis.

Is the service caring?

Good

The service was caring.

Staff relationships with people were caring and supportive. Through our observations and discussions, we found the staff were motivated and inspired to offer care that was kind and compassionate.

Is the service responsive?

Good

The service was responsive.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments through on-going discussions with

Summary of findings

them by staff and the providers. However, there was no complaints policy in place for people to refer to, neither was this available in an easy read format. Staff told us that any concerns were managed as part of their discussions with people.

People received personalised care and support specific to their needs and preferences.

Activities formed an important part of people's lives. People spent time participating in activities within the home and trips in the community.

Is the service well-led?

Requires improvement

Aspects of the service were not well-led.

The provider did not have systems and processes, such as regular audits and up to date and relevant policies and procedures in place to assess, monitor and improve the quality and safety of the service.

Staff spoke positively about communication and how the service was run. All agreed that they recognised team working as an important part of how the home was run and how there was an open culture whereby they could all raise issues without fear of retribution.

The organisation's visions and values centred on the people they supported. The organisation's statement of purpose and service user guide documented a philosophy of encouraging independence, choice, dignity and respect. The aim of the service was to provide a caring, homely and safe environment for people.

Little Eastbrook Farm

Detailed findings

Background to this inspection

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

This announced inspection took place on 28 April 2015. The provider was given 24 hours' notice because the location was a small care home for adults who may be out during the day; we needed to be sure that someone would be in.

The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received. We did not receive a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the providers and established that they had not received the request to submit this information.

We spoke with two people receiving a service, the providers and one care worker. We reviewed two people's care files, two staff files, staff training records and a selection of policies and procedures and records relating to the management of the service. Following our visit we sought feedback from relatives and health and social care professionals to obtain their views of the service provided to people. We received feedback from one relative, a GP and a chiropodist.

Requires improvement

Is the service safe?

Our findings

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicines. We saw that the home received people's medicines from a local pharmacy. These were supplied in their original boxes. We looked at the boxes and strips contained within and found them all to be in date.

Medicines were kept in a locked cupboard which formed part of the wall. The cupboard was locked by means of padlocks. This did not conform with the Medicines Act 1968 which states that medicines should be stored in a cabinet which complies with relevant standards and regulations. This meant that the storage of medicines within the home was not abiding by the legal requirements set out in legislation. However, the cupboard was kept in an orderly way to prevent mistakes from happening. The provider agreed to research the option of getting a cupboard which complied with UK law.

Medicines were safely administered. We saw the medicines recording records which were appropriately signed by staff when administering a person's medicines. However, there was not a system in place to ensure accurate stock levels and medicines remained in date. In addition, both staff training and the medicines policy and procedure were last updated in 2004. This posed a risk that medicines management did not reflect current legislation and guidance. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed that they felt safe and supported by staff at Little Eastbrook Farm and had no concerns about the ability of staff to respond to safeguarding concerns. Comments included: "I like living here"; "The staff are nice" and "I am happy here." We observed staff responding appropriately to people's needs and interacting respectfully to ensure their human rights were upheld and respected.

Staff demonstrated an understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. Staff told us they had received safeguarding training to ensure they had up to date information about the protection of vulnerable people. Staff records confirmed this information.

The registered manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an ongoing basis. We saw a copy of the organisations policy and procedure for safeguarding adults. It set out the measures which should be in place to safeguard vulnerable adults, such as working in partnership with the local authority. The policy included how to report safeguarding, which broke down the actions to be taken if an alleged safeguarding concern, had been identified. Staff confirmed that they knew about the safeguarding adults' policy and procedure and where to locate it if needed.

People's individual risks were identified and the necessary risk assessment reviews were carried out to keep people safe. For example, we saw risk assessments for falls management, physical health and self-harm when feeling stressed or anxious. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, the use of distraction techniques when a person was becoming distressed. Restraint was not used at the home to manage people's behaviours. Staff explained that speaking calmly and talking people through their emotions were the most effective ways to support people through difficult times.

Staffing was maintained at safe levels. Staff confirmed that people's needs were met promptly and felt there were sufficient staffing numbers. We observed this during our visit when people needed personal care, support or wanted to participate in particular activities. Staff were seen to spend time with people, for example chatting with people about subjects of interest.

Little Eastbrook Farm is run as a family home. We asked the registered manager about the home's staffing levels. The providers and one care worker delivered most of the care and support required by the two people living at the home, including any overnight help they needed. One of the providers and the care worker took responsibility for anything relating to personal care. The other provider involved the two people in daily domestic activities as well

Requires improvement

Is the service safe?

as providing trips out and enabling them to attend social events. People told us they were never left alone. The providers confirmed this and said that it would not be appropriate or safe to leave the home unstaffed, even for short periods. In an emergency, such as ill health, the providers would seek support from agency staff who live in the nearby village.

There was effective recruitment and selection processes in place for the one care worker who worked at the home. We saw pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. This demonstrated that appropriate checks were undertaken in line with the organisation's policies and procedures and to ensure she was safe to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People individual wishes were acted upon, such as how they wanted to spend their time.

Staff could not demonstrate a comprehensive understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied it to their practice, despite training completed on both subjects in March 2015. For example, staff did not think the MCA and DoLS applied to people with learning disabilities.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff were aware of asking people questions about a specific situation at different times to help them to consent and to assess their capacity on an on-going basis. We read two care files for people. Both did not contain any mental capacity assessments. We were told that these had not been needed to date and that they worked closely with health and social care professionals when needed.

People living at the home were not subject to any DoLS authorisations. If people wanted to go outside the property, staff would go with them to keep them safe. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Given the complex needs of people living in the home, this meant people without capacity may be at risk of having their freedom restricted unlawfully. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not directly tell us about staff training due to their learning disability. However, they told us, "Staff were nice."

Staff knew how to respond people's specific health and social care needs. For example, recognising changes in a person's physical health. Staff were able to speak confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported when feeling anxious through effective communication.

Staff had completed an induction when they started at the service, which included training. The induction enabled the organisation to assess staff competency and their suitability to work for the service. Staff informed us they received a range of training, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important to keep their skills up to date. We saw staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), infection control, first aid, health and safety and food hygiene. Training was delivered by distance learning. At the end of each training course, staff had to complete a test paper. The test papers were then sent to an external training provider for marking. However, despite staff receiving training in subjects relevant to people's current and changing needs, they did not have up to date medicines training and they could not demonstrate a comprehensive understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff received informal supervision on an on-going and informal basis due to the size of the service and team. There was no formal way of recording these sessions which would help recognise personal and professional development. The care worker told us that they had not received any annual appraisals of their work. However, she commented: "We discuss any arising issues on an on-going basis and I feel supported." Both the care worker and provider recognised that a formal way of recording would be beneficial and by the end of our inspection they had started to develop a tool to capture supervisions.

People were supported and encouraged to eat and drink. Staff cooked the main meals within the home and encouraged people to be involved in their preparation.

Requires improvement

Is the service effective?

People living at the home ate their meals as part of the family. People were provided with a wholesome diet which was balanced and nutritious. There was a menu in place and meals were generally planned around whatever people wanted to eat. People said they liked the food and it was apparent that they were looking forward to lunch on the day of the inspection. We observed how people were offered a choice of what they wanted to eat and drink. Snacks and drinks were available at any time. The provider told us they tried to ensure that a healthy diet was provided and to cater for individual choices and particular likes. Where people were at risk of weight loss or gain, their weight was monitored on a regular basis. Where changes in weight were evident the service ensured they contacted the GP for advice.

People were supported to see appropriate health and social care professionals when they needed to meet their healthcare needs. We saw evidence of GP's involvement in people's individual care on an on-going and timely basis. For example, a person had started having dizzy spells. The provider had contacted the GP and arranged an appointment for them so this could be investigated. People also received an annual medical check-up by their GP. These records demonstrated how staff recognised changes in people's needs and ensured other professionals were involved to encourage health promotion. A GP commented that they were very happy with the care their patients received at Little Eastbrook Farm. They added that the staff at the home were timely with their contact with the GP surgery and ensured people received follow ups when needed. They confirmed that they had no concerns about the service. Another professional commented that the service was friendly and people living there clearly were happy. They also had no concerns about Little Eastbrook Farm.

Good

Is the service caring?

Our findings

We spent time talking with people and observing the interactions between them and staff. Interactions were good humoured and caring. Interactions around the dining table involved everyone present to ensure no one was left out. Staff involved people in their care and supported them to make decisions. Comments included: "I like living here. I love the animals and cakes. I went to Weston-Super-Mare and had fish and chips" and "I like it here, it's nice. I like books." A relative commented: "I am very happy with the care X (relative) gets and have no concerns. If I had a concern I could speak up."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff told us how they maintained people's privacy and dignity when assisting with intimate care, for example by knocking on bedroom doors before entering and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. Staff supported people in a kind and empathetic way. Staff showed an understanding of the need to encourage people to be involved in their care. For example, how one person wished staff to talk with them about things which interested them.

Staff relationships with people were caring and supportive. For example, staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff spoke about how working as a team motivated them and how they gained inspiration from each other. Staff were observant to people's changing moods and responded appropriately. For example, we heard a member of staff supporting a person who appeared a little confused. The member of staff supported them in a caring and calm manner by talking with them about things which interested them and made them happy.

Staff were involving people in their care through the use of individual cues, and looking for a person's facial expressions, body language and spoken word. For example, when supporting a person with their meal. Staff gave information to people, such as what time lunch would be. People's individual wishes were acted upon, such as how they wanted to spend their time. We observed that staff communicated with people in a respectful way. This showed that staff recognised effective communication to be an important way of supporting people to aid their general wellbeing.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. They recognised that care plans needed to include people's involvement and were committed to ensure these plans were updated. Staff were able to speak confidently about the people living at Little Eastbrook Farm and each person's specific interests. They explained that it was important that people were at the heart of planning their care and support needs.

Good

Is the service responsive?

Our findings

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments through on-going discussions with them by staff and the providers. There was no complaints policy in place for people to refer, neither was this available in an easy read format. Staff told us that any concerns were managed as part of their discussions with people. The home had not received any complaints for many years, only compliments. One compliment stated: 'I think X (the provider) does a wonderful job and X could not be happier.' Both the care worker and one of the provider's recognised that a complaints policy needed to be formulated and they had started to plan this by the end of our inspection.

People received personalised care and support specific to their needs and preferences. For example, people's bedrooms were personalised to reflect their likes and personalities. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved.

People were involved in making decisions about their care and treatment through their discussions with staff and staff knowledge about the people they supported. Care files gave information about their health and social care needs. Care files were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, supporting people to identify specific activities to aid their wellbeing and sense of value.

Care files included personal information and identified the relevant people involved in people's care, such as their care manager and GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. People's likes, dislikes and preferences were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were up to date and were clearly laid out. They were broken down into separate sections, making it easier to find relevant information. For example, health needs, personal care, mental and emotional needs, activities and eating and drinking. Staff told us that they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

Activities formed an important part of people's lives to increase their independence. People spent time doing activities within the home and participated in trips in the community. People enjoyed spending time helping bake cakes, reading magazines, visiting local attractions and relaxing in the dining and living rooms. Staff commented: "It's about offering choice and promoting independence."

Requires improvement

Is the service well-led?

Our findings

Care plans and risk assessments were audited on an annual basis and at times of changes in people's needs. There were no other audits conducted by the provider, such as medicines management and staff support. This would enable any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Policies and procedures were also in need of being reviewed to ensure they reflected current legislation and guidance. It was difficult to ascertain when policies had been implemented, as there were no dates on any of them seen. For example, medicines management. We asked the staff when policies had been implemented and when they were last reviewed. We established that this would have been in approximately 2004. We also found that the home did not have a Mental Capacity Act (2005) policy in place to provide the legal framework to work within to ensure the protection of people in their care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke positively about communication and how the service was run. All agreed that they recognised team working as an important part of how the home was run and how there was an open culture whereby they could all raise issues without fear of retribution. When asked what the service did well and what they could improve on staff felt that what they did well was providing a caring environment for people, which was like home from home. They felt they needed to improve their IT skills and record keeping.

We established that staff meetings did not happen in a formal way. This was because of the size of the service and how staff discussed things on an on-going basis as they worked closely together. We asked staff whether they felt this method worked. They said that this was the best way to work due to the way the home ran. They felt that their views were listened to and acted upon. Resident meetings followed the same format, with discussions on an ad hoc and daily basis. The home was run as a family and things were discussed and activities planned during mealtimes around the dining table.

The providers used to seek the views of others through sending out surveys for people to complete. Families involved felt they did not want to complete these surveys as they were entirely happy with the care and support their relatives were receiving. We saw documented evidence of this decision during our inspection.

The organisation's visions and values centred on the people they supported. The organisation's statement of purpose and service user guide documented a philosophy of encouraging independence, choice, dignity and respect. The aim of the service was to provide a caring, homely and safe environment for people. Our inspection showed that the organisation's philosophy and aim was embedded in Little Eastbrook Farm through talking to people using the service and staff, observing the environment and looking at records.

There had been no contact from the service since our inspection in November 2013. We discussed this with the providers to check whether there had been anything which required us to be informed. From speaking with the providers and looking at records there had not been any issues which required us to be informed.

There was evidence of learning from incidents and appropriate changes implemented. For example, to mitigate a person's risk of falling the provider had encouraged the person to wear lace up shoes instead of slippers around the home. The person's care plan clearly documented this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The home did not have a system in place to ensure accurate stock levels and medicines remained in date and the medicines cupboard did not conform with the Medicines Act 1968. Both staff training and the medicines policy and procedure were last updated in 2004. This posed a risk that medicines management did not reflect current legislation and guidance. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems and processes, such as regular audits and up to date and relevant policies and procedures in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2)