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The Old Farm House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 January 2017 and was unannounced. The service is a residential service for up to 26 older people. At inspection there were 24 people in residence with one person in hospital. There are two shared rooms but one is currently used for single occupancy only. Accommodation is arranged over two floors with the majority of bedrooms having an ensuite facility, the service is fully accessible to those in wheelchairs or with mobility difficulties and the first floor is accessed by a passenger lift.

There was a registered manager in post. A registered manager is a person who is 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.

This service was last inspected in September 2013 when a shortfall in record keeping was highlighted, a follow up inspection in February 2014 checked that satisfactory improvements had been made and the service was assessed as compliant, these improvements have not however been sustained.

The leadership and management of the service were poor and required significant improvements to ensure people received care which met their needs and kept them safe. The provider and registered manager did not have an effective system in place to assess the quality of the service people received. People did not have robust risk assessments or care plans in place to ensure they received their care appropriately and safety, and in accordance with their wishes. Staff did not have the right guidance or information about people's needs, or how to recognise when there was deterioration in people's health. This placed people at risk of harm.

There were not enough staff in peak times to meet people's needs. Staff were constantly busy which meant that they did not always have time to support people with their needs. The recruitment checks of new staff did not meet the requirements of legislation.

A pre-admission process was in place but this was not always robust; some people were admitted with needs the service had not indicated they could meet in their statement of purpose; this will now needed urgent review. There were activities from time to time but no regular activity programme. There was a risk that people could become isolated and under stimulated.

The registered manager and staff did not have a good understanding of how to ensure people's rights were protected. The laws governing this (the Mental Capacity Act) were not followed, and some people had restrictions in place which deprived them of their liberty. When people did not have capacity to make decisions about their care, decisions were made on their behalf without consulting them or other key people to ensure the decision was made in the person's best interest.

Policies and procedures had not kept pace with changes in legislation; some policies viewed dated back to 1999 this meant staff practice was not being guided and informed by policies and procedures that were aligned to current statutory guidance and good practice. Staff had not received training essential to their roles, including training in how to care for people living with dementia and people with specific health conditions. New staff did not receive a robust induction and they did not receive training in essential areas such as safeguarding. A system for the formal supervision and appraisal of staff was in place but frequencies for providing these had drifted for the majority of staff; the registered manager was therefore unable to adequately monitor staff performance, training and development needs.

People did not always receive their medicines safely. When people required occasional medicines, for example: pain relief, guidance to inform staff when to give this, and how frequent was not sufficiently detailed. Some medicines were stored at very low temperatures which may impact on their effectiveness.

People had access to a range of health professionals, but the registered manager did not always ensure people's health needs were met in a timely way and there were delays in calling the GP or other health professionals. This placed people at risk of harm.

Although staff demonstrated they had the right attitudes for their role there were shortfalls in the way they had been recruited in that some important checks required by legislation had not been undertaken. The majority of servicing checks and tests of equipment were carried out at appropriate intervals but servicing of the electrical installation was outstanding by some years; a hoist assessed as being in a 'poor' state had not been replaced. These omissions could place people at risk of harm.

People told us they were happy and felt safe. Relatives were satisfied with the quality of care and support their relatives received. Meetings were held with people and they were asked to complete surveys about their experience of care but it was unclear how their feedback was used to improve the service; a service development plan was not in place.

Our observations showed many examples of positive interactions between staff and people who they treated with patience and kindness. People respected each other's privacy on a day to day basis and staff demonstrated they were respectful of people. Staff understood how to report and act on accidents and incidents appropriately.

Systems and processes for the ordering, receipt, storage, and disposal of medicines were in place. Staff understood how to keep people safe from abuse but their knowledge needed updating and the provider had already booked training for January 2017 to address this.

People were provided with a varied diet that was in keeping with their dietary needs and preferences.

People and relatives felt communication was generally good and that they were kept informed. They were confident of raising concerns if they needed to and where they had raised concerns felt they had been listened to and action had been taken.

We have made two recommendations:

We would recommend that existing fire arrangements including the frequency of fire drills for all staff, training in use of fire evacuation equipment and individual evacuation plans are reviewed by a competent person to ensure they comply with fire legislation.

We would recommend that the provider/registered manager seek information from a competent source about establishing end of life wishes for people, the use of end of life care plans and the appropriate training that staff would need to support people appropriately.

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 the 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 consistently safe

Risks to people were not managed to ensure their safety. There were not always enough staff to provide safe and effective care. Pre-employment checks and processes were not robust to ensure suitable staff were employed.

Appropriate arrangements were in place for the safe handling, storage and disposal of medicines, but the processes for giving people 'when required' medicines was not clear.

The premises were clean and well maintained but some equipment maintenance was outstanding and could place people at risk of harm.

Fire procedures were understood by staff, evacuation plans were in place but we have recommended fire drills frequencies, training with evacuation equipment and individual evacuation plans are reviewed.

Staff understood how to recognise and respond to abuse people could be subject to but needed updating on reporting. Servicing checks and tests of fire, gas and electrical installations carried out regularly. Accidents and incidents were appropriately reported and acted upon.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights were not always protected: The principles of the Mental Capacity Act and Deprivations of Liberty Safeguards were not well understood or implemented. Staff said they felt supported but formal support networks through individual planned supervisions and appraisal were not sustained.

Staff induction and training needed improvement to ensure they had the right knowledge and skills to understand people's needs and support them safely.

People's health needs were monitored but access to health

professionals were sometimes delayed. People ate a varied diet that took account of their preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff were busy and people's dignity could sometimes be compromised. People who were assessed as end of life might not have their needs or wishes supported appropriately. People's privacy was respected and staff treated people with kindness and patience. People and their relatives were happy with the care provided.

Staff promoted people's independence and ability to do more for themselves.

Staff supported people to maintain links with their relatives and representatives.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not always contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way.

There was a lack of activity provision to meet people's individual needs. People who remained in their rooms received very little mental stimulation or
interaction.

People were assessed prior to moving into the service, but the service could not demonstrate that their needs could always be met.

People and relatives told us they felt comfortable raising issues with staff and were confident these would be addressed.

Is the service well-led?

Inadequate

The service was not well led

Some monitoring was in place, but there was an absence of robust quality audits to provide assurance that people were receiving a service which met their assessed needs. The service had failed to keep pace with changes in care legislation and practice and policies and procedures were inadequate to

accurately inform staff.

People were asked to comment about the service but it was unclear how their comments were used to inform service improvement.

Staff said they felt supported and were given opportunities to express their views in regular staff meetings. However, some staff views were not acted upon.

People, their relatives, and staff commented positively about the service and the quality of care people received. CQC was appropriately informed of events in the service.

The Old Farm House Residential Home

Detailed findings

Background to this inspection

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

An unannounced inspection of this service took place on 9 January 2017 with an announced second day of inspection on 10 January 2017. The inspection team comprised of two inspectors.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we spoke in depth to 10 people and also spent time with two others who lived in the service, we observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We also spoke with one relative who was visiting and a health professional.

Not everyone in the service was able to speak with us so we used the strategic 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 also spoke with the registered manager, the registered provider, two deputy managers, two ancillary staff and four care staff. After the inspection we contacted relatives and received feedback from four.

We looked at 10 people's care, health plans and risk assessments. We checked medicine records, and three staff recruitment training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at The Old Farmhouse and that they were happy with the care they received comments included "I am happy living here and I would tell staff if I was unhappy." "I had fallen at home so I feel safer here." "I can't speak highly enough about the service." "I couldn't cope at home before coming here was the best decision I ever made, I feel safe now and it's taken all the worries off me."

One relative told us: "There is a nice atmosphere, the staff are nice and offer a lot of encouragement". Another relative said: "There are enough staff they are always busy but always take time to greet you".

Although people and relatives gave us positive feedback about the service, we found a number of areas which were not safe, and this placed people at risk of harm.

There were not enough staff on duty at peak times when people needed help or prompting with personal care. During our inspection we observed that people's personal care needs had not always been met. Several people were not dressed appropriately and had their undergarments showing. One person had most of their buttons undone on their blouse, and another person had not been assisted to get fully dressed and was partially in their nightwear and unshaven. Records showed some people had not had baths for some weeks and this was confirmed by one person who raised this with us, some people's nails were dirty and long. During the day shift there were four care staff on duty in the morning and this reduced to three in the afternoon with two waking night. No dependency assessment tool was used to determine the right number of staff that should be on duty to assist people.

Staff told us they did not have enough time to assist people or to spend time with them. A number of people chose to stay in their rooms, and only came out for meals. There was a lack of stimulation for these people and there was a risk they could become isolated. Staff said if they had time they would try to go and chat to people in their rooms but this was not achievable most of the time or documented when it did happen. Seven people needed the assistance of two staff to undertake their personal care for the morning routine. One person needed intermittent support with eating their meal dependent on whether they felt able to support themselves.

The failure to have sufficient numbers of staff deployed to meet people's needs is a breach of Regulation 18 (1) of the Health and Social care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

People's medicines were not always managed safely: Some people had medicines that were not provided in a pre-packaged dosage system, to ensure these medicines were administered safely and consistently it was important to put dates of opening on these medicines. This helped with medicine counts to ensure these had been administered correctly, this had also been highlighted in a pharmacy audit conducted in April 2016 but had only been implemented with eye drops and prescribed creams that needed refrigeration and not with all boxed and bottled medicines.

Some people were prescribed medicines to be administered when they needed them. These are called

'PRN' medicines. There was insufficient guidance in place for staff to know when these medicines should be administered. This could lead to people not getting their medicines when they needed them, or getting their medicines too frequently. For example, the protocols for one person said 'pain relief, look out for signs of discomfort she can have pain relief'. There was no description of how the person displayed discomfort or what this might commonly be for. This was especially important for staff to know as the person themselves had very limited verbal communication.

Staff had been trained to administer medicines but refresher training was not provided, staff competency to administer was assessed by the registered manager from time to time but without updated training people could be placed at risk because staff practice may not be current best practice or in keeping with changes in guidance in regard to medicine administration and management.

There was a failure to ensure all aspects of medicine management were managed well. This is a breach of regulation 12 (g) of the HSCA 2008 (RA) Regulations 2014.

Although there was good practice around processes for ordering receipt, storage and disposal of medicines we have asked the registered manager to consult with the pharmacist in regard to drug fridge temperatures; some of those recorded were very low and may impact on the effectiveness of medicines and be uncomfortable for those in receipt of very cold medicines.

Risks to people were not managed safely, and this placed people at risk of harm. There were no individual risk assessments for people who needed support with their mobility. Although each person had a generic moving and handling assessment this only identified what equipment and number of carers were needed, there was no guidance to staff in regard to the person's individual needs and wishes around this.

People who were at risk of developing pressure areas had risk assessments in place. However, equipment intended to reduce the risk was not properly maintained, and this omission increased the risk of pressure areas developing: for example one person had their airflow mattress set at 90Kg when their actual weight was below 60Kg this could have increased the risk of their developing a pressure area.

Some individual risk assessments had also been completed, for example one person undertook to administer their own medicines and a risk assessment was in place for this. Prescribed medicines were stored in an absent persons bedroom which was unlocked in a wall cabinet in the ensuite which was also unlocked. These medicines could be accessed by people and taken in error.

Falls risk assessments were not in place routinely even for those identified as prone to falls, although the service did use alarm mats for some people to inform staff when they were getting out of bed. One person had a risk assessment for falling from a first floor window but there was no clear rationale as to the reason for this. Another person had a risk assessment for lunchtimes that said "At lunchtime X is to be first into the dining room or the last" the risk assessment did not say why this was or the risks of not following it.

Some people had risks related to their specific health conditions for example epilepsy, diabetes or, respiratory problems. Assessment of the risks attributed to these conditions that staff needed to be aware of were not in place. This could mean that staff would not understand the risk the person was at or take the appropriate action to minimise this. For example when we spoke with staff they were unaware that one person had epilepsy and there was a risk of seizures, they confirmed they would not know what to do if that happened. Another person's record stated they had a catheter but a risk assessment had not been completed to alert staff to the potential risks this could have for the person and what they needed to do to minimise these. The same person's general risk assessment stated that all equipment needed to be used

with the person along with two staff and that the person should only be transferred from one area to another using a wheelchair. We met this person during the inspection; they had brought themselves down in the lift and was moving around the building from communal area to dining room without a wheelchair or the supervision of staff, the risk assessment did not therefore reflect everyday staff practice.

Staff did not know how to safely evacuate people in the event of an emergency. Although specialist evacuation equipment was in place, staff told us they had not been trained in how to use it. Personal emergency evacuation plans (PEEPS) had been developed for people in the service but these would benefit from additional detail to make clear to how staff how they should evacuate people as there was there was an over reliance on this being left for the fire service to do.

Evacuation equipment had been purchased but this was not detailed in individual PEEPs for those it would be appropriate for. A business continuity plan (This is a plan of actions to be taken by the registered manager and staff in specific emergency situations) was in place in regard to a range of events that might stop the service from operating normally for example, poor weather preventing staff getting to work. This covered a range of eventualities so that staff would know what to do and could implement emergency procedures, at inspection the registered manager was not familiar with this document and this had not been shared with staff and was not readily available to them.

There was a failure to ensure a robust system was in place for the identification and mitigation of risks people experienced either from their environment or from their own care and health support needs. This is a breach of Regulation 12 (1) (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014.

People were at risk from unsafe equipment and their safety was compromised. An electrical contractor visit in 2009 to check the electrical installation recommended a follow up visit one year later but this did not take place and was long overdue.

There were two mobile hoists located on the ground and first floor; these were serviced regularly but at the last service in August 2016 one was assessed as being in a poor state. Since then the hoist had not been replaced whilst we were informed that no one upstairs needed to use a hoist at present staff said in the event that someone fell who was located on the first floor, they would have to bring the ground floor hoist upstairs which would take time and would delay people being helped. These omissions could place people and staff at risk of harm.

One person had oxygen bottles in their bedroom, staff were aware of this and the persons personal evacuation plan made reference to this as a potential safety hazard in the event of a fire. Warning notices to easily alert fire crews in the event of a fire to the presence of oxygen in the building placed at the entrance to the building and on the door of the person's bedroom were not in place; this could place people helping with evacuation at risk of harm.

People were at risk because there was a failure to ensure that all required servicing of equipment within the premises had been undertaken, repaired or replaced in accordance with the recommendations of external contractors where necessary or that appropriate safety signage was in place. This is a breach of Regulation 15 of the HSCA 2008 (RA) Regulations 2014.

Staff showed an understanding of safeguarding and how to protect people from harm, they were confident of escalating issues through the registered manager and /or provider if needed but training had not been provided for some years, newer staff some that had not completed the training were less sure about where they would take concerns outside of the organisation. The registered manager had recognised there was a

development need and had already booked training for the end of January 2017; all staff were aware of the training which was to be in two sessions on the same day so that staff were available to support people during the course of each training session.

An appropriate system was in place for staff to record accidents and incidents that occurred within the service. When accidents happened staff took action to ensure the wellbeing of the person involved and check whether they required medical intervention immediately or just monitoring. Other accidents or incidents might be referred to health professionals for advice or assessment , for example the mental health team in regard to incidents of behaviour; this helped to ensure people received the right support and that they or others did not come to harm. Staff completed reports for all incidents and accidents and these were reviewed by the registered manager to see if there were any common themes or patterns.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us the food at the service was good, and included lots of choices. We had mixed views on whether people's healthcare needs were always met. Some relatives felt their loved one's needs were promptly met: "They are very quick to respond to emergency health situations my relative had a mini stroke and staff picked this up and the person was in hospital within minutes", whilst others felt there were delays: ""There has been a bit of a delay in seeing an optician- we are not sure why it is taking so long?" A healthcare professional told us: "staff implement the advice and guidance we give them, and I have no concerns."

People did not always have their health needs met in a timely way. This placed people at risk of harm. When asked, the registered manager could not give us a reason for delays in calling the GP, specialist nurse or another health professional when health concerns for individuals were identified. Several staff commented that there were delays sometimes in the doctor being called. One person's record showed their referral to a GP had been delayed by three days even though staff had raised concerns that the person was unwell, a relative expressed concern at the unexplained and lengthy delay of months with regard to an optician visit to the home being arranged for their relative and this was still outstanding. A third person who had received a visit from a specialist nurse was concerned that a request for a further visit had not been made on their behalf even though they said they had expressed concerns about further deterioration.

Some people had complex health needs such as diabetes, epilepsy and respiratory conditions. Although these conditions needs specific monitoring, treatment and care, no one with these health conditions had a separate health care plan this described the condition, treatment, signs or symptoms. This meant that staff had no guidance to enable them to care appropriately for individuals, and respond in a timely way when necessary. Staff did not know what action to take if there were any signs of deterioration.

People were at because there was a failure to ensure that deterioration in health was always acted upon and that staff were provided with appropriate guidance and information to understand and support specialist health care needs. This is a breach of Regulation 12 (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014.

Staff had not consistently received training appropriate to their role, and this impacted on the care and support people received. A training matrix was in place, this had not been updated to take account of some new staff but did show that mandatory training for staff in areas such as first aid, fire, moving and handling, infection control, food hygiene, health and safety was provided but not on a regular basis to ensure that staff knowledge was kept updated about current best practice and changes to legislation when training certificates ran out. Staff spoken with said they would like more training updates. Some people living in the service had conditions such as diabetes, epilepsy and dementia but the majority of staff had not received training to enable them to understand these conditions and support people appropriately. Staff had to deal with some behavioural issues from time to time but had not received any training in behaviour management and de-escalation techniques to give them confidence when dealing with issues of this nature.

New staff were subject to a six months probationary period and the registered manager said they completed a three week period of shadow shifts before going onto the rota as a full member of the team. The recruitment procedure did not make clear the probationary process and how this would be monitored, staff induction and supervision records did not make the distinction clear between probationary and normal supervision sessions. The registered manager was able to show that there were a range of DVDs that new staff were expected to view and afterwards complete an online test but it was clear this was not consistently used with all new staff and there was no evidence of workbooks being signed off or recorded on the staff files. The registered manager was aware of the new Care Certificate (The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life) but this had not been implemented to replace existing induction.

There was a system for the formal supervision of staff by the registered manager and deputy managers. In these sessions staff members could discuss their training and development needs and work related issues. Staff said they felt well supported and there was a good sense of 'team'. A supervision schedule was kept of when staff had received supervision but this did not record all the staff currently employed as it had not been updated to take account of new staff. The PIR informed us that 19 staff were eligible for supervision but the schedule showed that only six had received supervision on average three to four times during 2016. For the remainder of staff supervision frequency ranged from none to one during 2016. Some staff were new and on probation and there was an expectation they would have received more frequent formal supervision to assess progress towards meeting their probation. A process for the annual appraisal of the performance of staff in post for more than one year was in place. The PIR provided informed us however that only two staff had received an appraisal in 2016.

Systems for the induction, training supervision and appraisal of staff were not implemented robustly and there was not good oversight or understanding of staff performance training and development, this is a breach of Regulation 18 (2) (a) of the HSCA 2008 (RA) Regulations 2014.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). Some people met the criteria for a Deprivation of Liberty Safeguards (DoLS) authorisation to be applied for because their liberty was restricted for example through use of sensor mats and locked doors, or having decisions made on their behalf without appropriate authorisation, but no applications had been made to the DoLS team to progress this. The registered manager had some understanding of decisions being made on people's behalf in their best interest but she and a number of other staff that had not received training in MCA or DoLS in how to implement the principles of the MCA 2005 into their everyday practice, other staff were now overdue on their update training for this.

Staff sought verbal consent from people in their everyday support but people's capacity to make everyday decisions was not assessed, where there was a need for a best interest decision to be made this was not recorded. The Provider Information Return (PIR) informed us that 16 people were subject to Lasting Power of Attorney but documentary evidence of these authorisations had not been seen and recorded by the provider or registered manager to assure them that this was the case. Consent to room share for two people was not in place and this had not been reviewed to ensure the people concerned were still happy with this arrangement.

There was a failure to implement the principles of the Mental Capacity Act 2005 and Deprivations of Liberty Safeguards and this is a breach of Regulation 11 (1) (3) of the HSCA 2008 (RA) Regulations 2014.

People enjoyed the food they received. There were two cooks and menus were developed from an understanding of people's dietary needs and preferences. People either put in their meal orders the evening before or in the morning, this was recorded on a tick box sheet. Records showed people ate a varied range of meals. People told us that alternatives were always available if they did not like what was on offer and one person visited the kitchen every day to check the options and choose something different if necessary. People were able to have a cooked breakfast if they wished. One person needed staff support sometimes to prompt and encourage them to eat but could manage this for themselves on other days. Staff monitored what people ate and drank to ensure they maintained a good diet. Food or fluid monitoring charts were put in place for a short while if there were any concerns; if people's appetite did not improve they were referred initially to the GP. Staff said people were weighed monthly unless there were concerns; if so they would be weighed more often. Food supplements had been prescribed for some people whose nutritional intake was not very good.

Requires Improvement

Is the service caring?

Our findings

Relative's comments included "It feels lovely and homely like a friendly B&B." "They may not be up to all the standards but she is so well looked after and staff are so patient with her." or "As soon as she buzzes staff are there." Another said "Staff are kind, open and honest, any concerns they contact me." A fourth said "Once or twice a week I visit I can turn up whenever I wish, as soon as she moved in staff put her pictures on the wall to make it hers. They said any furniture could be brought in."

People's comments included "I have not had a bath for three weeks." Several others told us that they had a shower every week, and another person told us "I have a regular bath and can ask for another if I want it," "I am so happy here".

Relatives and people in general felt that staff gave people respectful and dignified care and support. Our observations however made us concerned that sometimes people's dignity could be compromised by staff not having the time to check that a person's appearance was what it should be particularly if the person was responsible for dressing themselves. This was evident on three occasions during the inspection. On the first day we met someone who dressed themselves but was wearing their blouse inside out and it was only closed by one button, their undergarments were clearly visible on pointing this out to passing staff the person was encouraged to go into their room and put the blouse on properly, when they returned the blouse was still inside out and undone but a cardigan had been put over the top which was still unbuttoned. Staff buttoned up the cardigan to protect the person's modesty.

On another occasion we met someone who was dependent on staff for their personal care and support with dressing, the neck of their clothing was quite open and on further observation we noted the persons blouse underneath was not fully buttoned up. A third person we met late morning who had been unwell the previous week was still in their room in pyjamas, they were unshaven. They seemed keen for peoples company. We saw them again later waiting to go into lunch they were still unshaven although their care plan stated they liked a wet shave, they were dressed in trousers with the pyjama top we had seen them in earlier.

There was a failure to help people maintain their dignity and this is a breach of Regulation 10 (1) of the HSCA 2008 (RA) Regulations 2014.

Staff did their best in the time allotted and were supportive and encouraging of people's desire to remain as independent for as long as possible, there was however, a need to ensure this did not lead to a lack of care because those same people did not request help for themselves.

People freely moved between their bedrooms and communal areas and in between meals; drinks, snacks (crisps and sweets) were left in communal areas for them to help their selves.

Staff demonstrated kindness and patience and we saw many examples of positive interactions between staff towards people they supported from a greeting and enquiry as to how someone was to listening to

what people were saying and acting upon this for example, one person was not enjoying her lunch and expressed this to a staff member who was bringing in the pudding, the person asked if they could have 'Weetabix' a favourite of theirs instead which the staff member went and got for them.

Staff showed themselves to be kind and helpful and people told us staff responded quickly to their requests for support or expressed need, for example one person asked for a tissue and this was quickly provided. Staff supported people with their personal care discreetly.

People were able to bring personal possessions to decorate their bedrooms and the majority of rooms were of a good size and very personalised with items of importance to remind people of who they were and who was important to them. People did not have keys to their rooms but people respected each other's privacy. Some people had patio doors out onto the garden and took pleasure in growing flowers in pots and having feeding stations to attract birds to their area of the garden.

People's care plans contained some information about the important people in their lives and some important events they needed to be reminded about. Where possible the person and/or their relatives had been asked about the person's background so that a social history could be developed. This helped staff understanding of the person and provided opportunities for them to build a relationship with the person through talking about some of their history and background. People and relatives told us that the registered manager consulted them about the care plan and they were satisfied with the support provided but there was no evidence of their involvement or signature on their care plans to say they consented to what was written and this is an area for improvement.

Relatives said they were always made to feel welcome whenever they visited and did not feel there was any restrictions placed on when or how often they visited.

People had access to daily newspapers to keep them informed of local national and worldwide events, not everyone liked to read some people said they liked to chat but found very few people in the service with whom they could now do so for any length of time. They said care staff and the cleaner were always pleasant and chatted a little when they were doing things in the room but some people missed having like-minded people with whom they could spend time talking and we have already highlighted that some people who kept to their rooms were at risk of becoming isolated. People told us about the visitors they had and how they kept in touch with family and friends through their own landline telephones or mobile phones.

No one at the service was considered to be in need of end of life care at the time of our inspection, staff had not received training in this area and there was no evidence of end of life discussion or end of life care plans available for use if someone became end of life. The PIR informed us that 19 out of 25 people were subject to a 'Do Not Attempt Resuscitation' (DNAR) this is a document issued and signed by a doctor, which tells care staff and medical professionals not to attempt cardiopulmonary resuscitation (CPR). The registered manager reviewed DNAR decisions each month with people or their relatives to ensure this was still what they wanted; we were not shown the original documents to evidence consultation with people or their relatives around this very sensitive area. As no capacity assessments were completed for people it was unclear how people's capacity had been judged to inform the DNAR decision and we have highlighted this shortfall elsewhere in this report.

We would recommend that the provider/registered manager seek information from a competent source about establishing end of life wishes for people, the use of end of life care plans and the appropriate training that staff would need to support people appropriately.

Requires Improvement

Is the service responsive?

Our findings

People told us "If there is anything on downstairs I go down for it but, I don't mind my own company either, I have no complaints it's been quite good here." "I would not want activities – I get regular visitors, I get asked about my care plan by the manager, I feel able to complain if I needed to." Another said "I've settled here now it's my home but I do get bored because I can't do some of the things I used to." I did mention a concern about a staff member's attitude and something was done about it because other people were not happy either."

Relatives told us "Since she been there she has done more than she did at home." "We have no gripes but not sure he has enough to do." "I was told about the complaints procedure at the beginning but have not had to make a complaint. I think the manager would deal with any concerns."

A staff member commented: "We feel like this is more nursing, not just residential. We have people with mental health issues; I think we need the right residents. Admission happens too quickly and I don't think the right people are always admitted, there is pressure."

There was no specific budget for activities and no staff member appointed to take on the role to facilitate activities. Some external entertainers were booked to come into the service from time to time and people enjoyed these events, however, these were not provided on a regular basis. The registered manager booked access to a minibus approximately four times annually and this was used to take a small number of people out to garden centres, shopping or other nearby places of interest this was not able to accommodate people in wheelchairs and was not always well attended although further bookings were in place for February and May 2017. There was no established programme of activities on a week to week basis that people could choose to participate in or not, a volunteer came in on a Sunday to play scrabble and chess with those that wanted to.

People we spoke with said they did not go downstairs in to communal areas except if there was something on, some people said that they preferred their own company and would not participate in activities and others liked to spend time in the communal areas sitting companionably with others if not necessarily active. The registered manager told us that sometimes quizzes were held and we heard a staff member trying to engage people in a sing along at inspection. Such activities were dependent on staff availability and therefore provided on an ad hoc basis. People were not provided with regular opportunities for mental stimulation, and engagement with others to avoid isolation.

Not enough was being done to ensure people's individual preferences around stimulation, activity and engagement were addressed and this is a breach of Regulation 9 (1) (a) (b) (c) of the HSCA 2008 (RA) Regulations 2014.

A care plan was developed from pre-admission information gathered prior to admission and in the first week of admission. This should provide guidance to staff about people's daily routines their needs and how they preferred these to be supported. People had care plans and these were reviewed by the registered

manager on a regular basis. Records viewed showed care plans to largely be made up of a series of statements about the person with little detail to guide staff in offering a personalised support in keeping with each person's needs wishes and preferences. For example one care plan said 'is a people watcher, staff to encourage this' the care plan does not inform staff how they should achieve this, the plan also states 'Enjoys music'- staff to take an active role on a one to one basis.' No description was provided of what type of music the person preferred or what 'taking an active role' might mean for staff. The person in question had limited verbal communication and the care plan states 'Does not speak very much'- observe body language and facial expressions' this does not inform staff what body language they should be looking for and what it might mean and was therefore open to interpretation by different staff. For another person the care plan told us that the person liked the radio and this needed to be put on for them but no further details were given as to what their preference was to music or talk stations or particular favourites, the persons plan also said they needed to go out for a coffee on a weekly basis but these outings were not recorded and in conversation the manager agreed these were no longer happening as the person had not enjoyed them; the care plan had remained unchanged. For another person the care plan stated "not always safe in her room, if in her room staff to check", there was no information about why the person might not be safe, what staff needed to be checking for, and at what intervals they should be checking. There was no evidence to indicate that checking was implemented if the person went to their bedroom and records of checks made by staff at night and at other times were not always well completed.

There was a failure to provide a personalised plan of care to inform and guide staff in the support people needed to provide and this is a breach of Regulation 9 (1) of the HSCA 2008

Many of the people living at the service had lived locally all their lives and had fond memories of the 'Old Farmhouse' when it was a working farm. Some people had known the home in later life having visited friends who were then resident and had made the decision then that they wished to move there eventually. We met one person who had visited the service prior to coming to live there permanently; they said it was their decision to come to the service. The registered manager explained that usually people were assessed prior to admission and were provided with opportunities to visit if they were able, sometimes relatives visited on their behalf. Pre admission information viewed was supplemented by information provided by other health and social care professionals so provided a detailed understanding of the persons care and support needs. There was a concern however that without these additional reports the preadmission process was not sufficiently robust to ensure the service was only taking people whose needs could be met, for example the registered manager informed us that some people had been admitted with a formal diagnosis of dementia that had not been picked up during the pre-admission assessment and this is an area for improvement.

A complaints procedure was displayed for people to view. People and their relatives said they felt confident of raising concerns with the registered manager or other staff if they had them and said they found staff approachable and open.

A complaints log was maintained by the registered manager for recording of formal complaints received. The PIR informed us and the registered manager confirmed that in in the 12 months preceding the completion of the PIR in March 2016 there had been 15 complaints received these were all resolved; these were recorded in the complaints log with evidence of the investigations undertaken. People were also provided with opportunities through surveys to express any matters of concern which they thought needed to be addressed.

Inadequate

Is the service well-led?

Our findings

One person said "I do feel listened to I spoke to the manager about something and she sorted it out quickly which made me feel a lot better."

Relatives told us: "We are really pleased with her care"; "there is not an autocratic style of management." "We are asked to complete a questionnaire." "The manager sits down with people and goes through the care plan with them and us." "Staff make every day light; they are always chatting to people."

A staff member told us: "We really do care about people and are not here for the money, what's wonderful is that there is no bullying between staff, the team works really well we really care for one another and we get attached to the people. We maybe behind with certain things but we really care."

Although comments from people and relatives were positive about the management of the service, we found that leadership at the service was poor and required significant improvements to ensure people's needs were consistently met. The service did not have an effective quality assurance system in place to drive improvement in a sustained and proactive way. The provider conducted regular monthly visits which mainly focussed on the environment, and made some reference to speaking with people, staff and reviewing documents. Information recorded regarding these visits was minimal and provided no insight into what was spoken about or found and whether there were actions from the visit. For example at a provider visit on 27/10/16 the written comment said 'EH feels all is well'. This visit highlighted that more work was required in regard to quality assurance but did not give more information about what this should be or how to achieve this and by when. Other than a medicines audit there was an absence of any other audits to look at health and safety, catering cleaning, care plans and other documentation including staff training and supervision to check for completion. The absence of such audits meant that the registered provider and registered manager could not assure themselves that service quality in all areas was being met or maintained.

The Statement of purpose (SOP) for the service had not been reviewed. The SOP was clear that the service was for older people. People were now being admitted to the service however, whose needs fell outside of those recorded in the SOP. The provider and registered manager needed to urgently review whether this was the direction they wished to take and take measures to provide staff with the necessary training, knowledge and skills to be able to support older people with additional needs.

The registered manager had been in post for fifteen years. They had not kept their knowledge and skills updated sufficiently to develop the service. This impacted on the quality of care people received.

Staff recognised that the registered manager worked hard and was trying to improve things but were informed the availability of funding was an issue, and this was confirmed to us again by the registered manager. Overall staff said that they felt supported by the registered manager.

Staff said the provider visited often and some said they found the provider 'pleasant' and a 'nice person' but they felt there could be improved investment in the training of staff, activity provision for people and

development of the dining area so that everyone could be accommodated there. All the relatives we spoke with were complimentary of the service provided to their family member.

Staff said that there was good team support and this made them feel supported and listened to. The atmosphere within the service on the days of our inspection was relaxed, open and inclusive. Staff thought communication was generally good; they said they were kept informed about changes to operational policy or the support of individuals usually through handovers which were verbal or through formal staff meetings which were held at regular intervals with four held in 2016. Staff were given opportunities to express their views at staff meetings but it was unclear what action if any was taken on issues raised, for example a night staff meeting on 01/08/16 said seven residents required two staff to assist them. At a previous meeting on 07/03/16 the staff said they felt that there was too much being put on them at night with only two carers. They indicated that the workload was increasing due to the increased night time dependency of people and they were concerned that they were not always able to provide the support to the standard they wanted to. The registered manager confirmed that this matter had been discussed with the provider but funding issues related to the people concerned whose needs had increased meant this remained unresolved. There was no record of subsequent discussions or requests for additional funding to funding agencies.

Staff had access to policies and procedures, but these were not reviewed regularly and most had not kept pace with changes in legislation and good practice guidance with some dating from 1999 and 2000. Most policies and procedures seen were brief with little relevant information or guidance available to inform staff practice and ensure this was conducted to required standards.

People and relatives told us that surveys were conducted and the Registered manager analysed this feedback, however there was little evidence as to how comments received informed improvements to service quality and this was not reported back in newsletters that had been sent out to people in August and September 2016, the registered manager had introduced these to enable people to be kept up to date with birthdays and for coming events and services which were now available for example, Skype.

A business summary plan was in place for 2016 which highlighted what improvements had been implemented in regard to the environment and improvements to the quality and skill level of staff employed. There was however no development plan for planned improvements for 2017 and beyond which would usually be informed through audit processes and feedback from people or professional's.

The language used within records reflected a positive and professional attitude towards the people supported, and this was reflected in staff practice observed throughout the inspection, however, information about individual people was not always accurate or clear, or person specific to provide guidance to staff and inform their practice and support of people.

The failure to ensure systems and processes were in place to assess, monitor and improve the quality of the service, the failure to assess, monitoring and mitigate risks to people, and the failure to maintain accurate records in relation to people and staff is a breach of Regulation 17 of the HSCA 2008 (RA) Regulations 2014

The registered manager ensured that the Care Quality Commission was notified appropriately and in a timely manner as and when notifiable events occurred.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to provide a personalised plan of care to inform and guide staff in the support people needed to provide and this is a breach of Regulation 9 (1). Not enough was being done to ensure people's individual preferences around stimulation, activity and engagement were addressed and this is a breach of Regulation 9 (1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was a failure to help people maintain their dignity Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to implement the principles of the Mental Capacity Act 2005 and Deprivations of Liberty Safeguards and this is a breach of Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure a robust system was in place for the identification and

mitigation of risks people experienced either from their environment or from their own care and health support needs. Regulation 12 (1) (2) (a) (b).

People were at because there was a failure to ensure that deterioration in health was always acted upon and that staff were provided with appropriate guidance and information to understand and support specialist health care needs. Regulation 12 (2) (a) (b)

There was a failure to ensure all aspects of medicine management were managed well. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were at risk because there was a failure to ensure that all required servicing of equipment within the premises had been undertaken, repaired or replaced in accordance with the recommendations of external contractors where necessary or that appropriate safety signage was in place. Regulation 15 (1) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a failure to ensure that the recruitment of new staff is robust and in accordance with current legislation is a breach of Regulation 19 (2)(3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to have sufficient numbers of staff deployed to meet people's needs. Regulation 18 (1).

Systems for the induction, training supervision and appraisal of staff were not implemented robustly and there was not good oversight or understanding of staff performance training and development, Regulation 18 (2) (a)

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 17 HSCA RA Regulations 2014 Good governance The failure to ensure systems and processes were in place to assess, monitor and improve the quality of the service, the failure to assess, monitoring and mitigate risks to people, and the failure to maintain accurate records in relation to people and staff is a breach of Regulation 17 (1).

The enforcement action we took:

We have issued a warning notice.