Key inspection report

Care homes for older people

Name:	Eastfield Farm Residential Home Limited
Address:	Eastfield Farm Residential Home Limited Halsham East Yorkshire HU12 0BP

The quality rating for this care home is:	zero star poor service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Diane Wilkinson	1	8	0	2	2	0	1	0

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Author	Care Quality Commission
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Information about the care home

Name of care home:	Eastfield Farm Residential Home Limited
Address:	Eastfield Farm Residential Home Limited Halsham East Yorkshire HU12 0BP
Telephone number:	01964671134
Fax number:	F/P01964671134
Email address:	eastfield.res@neoeon.com
Provider web address:	

Name of registered provider(s):	Eastfield Farm Residential Home Limited
Name of registered manager (if applicable)	
Mrs Tracy Ann Davies	
Type of registration:	care home
Number of places registered:	26

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
dementia	0	26
old age, not falling within any other category	0	26
Additional conditions:		
The maximum number of service users who can be accommodated is: 26		
The registered person may provide the following category of service only: Care home only - Code PC, to service users of the following gender: Either, whose primary care needs on admission to the home are within the following categories: Old age, not falling within any other category - Code OP and Dementia - Code DE(E)		

Date of last inspection								

Brief description of the care home
Eastfield Farm Residential Home is a privately owned care home that is registered to provide care and accommodation for 25 older people, including those with dementia related conditions.

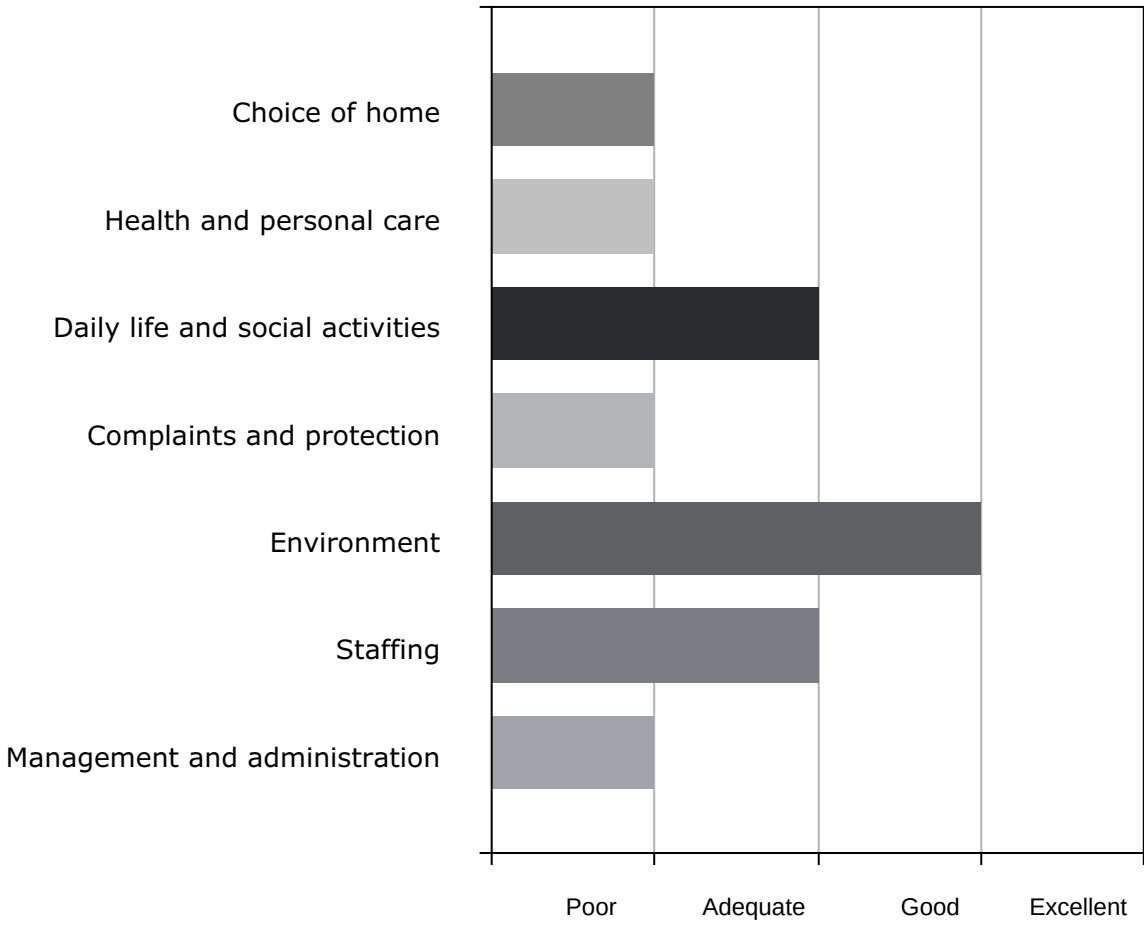
Brief description of the care home
The home is situated in a rural setting and local amenities are only accessible via public transport or car. Communal space comprises of three lounges and a dining room - some of these areas have views over open countryside. Private accommodation consists of seventeen single rooms and four shared rooms - eleven of the single rooms and one of the shared rooms have en-suite facilities. There is a lift to the first floor so all areas of the home are accessible to the people who live there. The garden is easily accessible for service users and in the summer benches, tables and parasols are placed outside. There is ample parking space at the front of the building.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	zero star poor service

Our judgement for each outcome:



How we did our inspection:

This inspection report is based on information received by the Care Quality Commission (CQC) since the last key inspection of the home on the 22nd November 2007, including information gathered during a site visit to the home. The unannounced site visit was undertaken by one inspector over one day. It began at 11.00 am and ended at 5.00 pm.

On the day of the site visit the inspector spoke on a one to one basis with three members of staff and a director of the company, and chatted to the people who live at the home. Inspection of the premises and close examination of a range of documentation, including four care plans, were also undertaken.

This inspection was arranged at short notice so on this occasion we did not ask the registered person to complete an Annual Quality Assurance Assessment (AQAA) form. The AQAA is a self-assessment that focuses on how well outcomes are being met for

people using the service. In addition to this, we did not send out any surveys as part of this key inspection.

A random inspection was carried out at the home on the 2nd February 2010 by a CQC pharmacy inspector. This was as a result of issues about medication practices at the home being identified during a recent safeguarding investigation undertaken by the Police and Social Services. The findings of that inspection are included in this report.

At the end of our site visit, feedback was given to the director of the company on our findings, including requirements and recommendations that would be made in the key inspection report.

The home's secretary told us that the current fee for residential care at the home is from £362.04 to £410.20 per week.

We have reviewed out practice when making requirements to improve national consistency. Some requirements from previous reports may have been deleted or carried forward into this report as recommendations - but only when it is considered that people who use services are not being put at significant risk of harm. In future, if a requirement is repeated, it is likely that enforcement action will be taken.

What the care home does well:

Meal provision at the home is good with a variety of choices being on offer at breakfast time and tea time.

The home is maintained in a clean and hygienic condition. It is well decorated and furnished and is designed to give people views of the open countryside.

A new treatment/sensory room has been created; this provides people with a private area to see health care professionals and a quiet area to relax away from other people.

At the request of people living at the home, a second jacuzzi bath has been installed and there is now a shower cubicle in one bathroom so that people have a choice of having a bath or a shower.

There is an effective staff rota in place that records the role of each member of staff on duty and evidences that there are sufficient numbers of staff to meet the needs of the people living at the home.

Staff have induction training when they first start work at the home that provides them with the information they need to carry out their role.

What has improved since the last inspection?

No requirements or recommendations were made at the time of the last key inspection.

What they could do better:

People must have a care needs assessment prior to their admission to the home so that they are only offered a place if it is considered that their assessed needs can be met.

Thorough and personalised care plans must be in place; these should be based on the information that is gathered at the time of the initial assessment and then reviewed and updated accordingly. Failure to do so may result in staff not having the information they need to meet each person's individual care needs.

Daily records of the care provided to people should be included with care planning information so that there is a full and up to date record to evidence that the care provided meets a person's assessed needs.

Risk assessments on pressure care, nutritional needs, the risk of falls and the use of bed rails must be in place for people living at the home. These must meet current good practice guidelines and must be reviewed and updated on a regular basis.

Medications policies, procedures and practices at the home must improve and must be based on current guidelines and advice. All staff must be trained in safe medication handling and shown to be competent to give and record the use of medications.

People should be offered a true choice of meal at lunchtimes.

Some activities are provided for people; an external provider provides a written record of any activities people take part in but other leisure activities are not recorded. This results in care plans not providing enough evidence to show that people live their chosen lifestyle.

Complaints should be recorded in a complaints log so that there is a record of the complaint made, the investigation and any action taken. It would be good practice to introduce a way of recording any concerns or grumbles and what action has been taken to alleviate these.

All staff must have training on safeguarding adults from abuse so that the responsible persons can be confident that staff can recognise good practice and poor practice, and know what action to take should they observe poor practice or incidents of abuse.

The home should continue to encourage staff to work towards NVQ Level 2 in Care so that they have a well qualified staff group.

All safety checks must be in place prior to people starting work. When people start work following receipt of a ISA Adult First check but before a satisfactory CRB check has been received, there must be a written record of the supervision arrangements in place for that person.

There must be a full record of the training achievements and needs of the staff group. This includes the date that the training was undertaken by staff so that the need for refresher training is highlighted.

The responsible persons must ensure that all policies and procedures have been read and understood by staff and that there are systems in place to ensure that they are followed and implemented.

Any systems in place to check that the fire alarm system is in good working order must be followed consistently.

We saw that some members of staff had been disciplined on several occasions and this suggested that the homes disciplinary procedures are not followed in some instances.

The Care Quality Commission must be notified of all incidents and accidents at the home that affect the welfare of the people living there. The local authority must be informed of all safeguarding incidents and the Care Quality Commission should be informed of any safeguarding alerts that are sent to the local authority.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.
You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line 0870 240 7535.

Details of our findings

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Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.

People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at the outcomes for Standard 3. Standard 6 was not assessed on this occasion as there is no intermediate care provision at the home.

Some people have day care or respite care prior to making a decision about permanency and this helps with their decision making process. However, some people do not have a full care needs assessment prior to their admission to the home and this could result in people whose needs cannot be met being offered a place.

Evidence:

We checked the care records for four people who live at the home, including one person who has had respite care. We noted that some people have day care and/or respite care at the home prior to living at the home on a permanent basis; this helps people to reach a decision about permanency.

Two of the four people had a community care assessment and care plan in place that

Evidence:

had been produced by the local authority commissioning the placement. The other two people had no care needs assessment in place, either from the local authority or that had been undertaken by the home.

There was no evidence that people are visited at home prior to their admission so that the assessment process can commence. In one care plan the admission record stated, 'initial assessment on arrival' which led us to believe that the assessment process commenced on the day the person arrived at the home. The assessment recorded a brief medical history, information about mobility and the comment 'mentally good' - there were spaces on the form to record pressure relief, skin condition, appetite and incontinence but all were blank. Other assessments that we saw were also very brief. A full care needs assessment must take place prior to a person moving into the home, apart from in emergency situations; the care needs assessment should address all of the person's care needs.

It would be good practice to obtain information from family and friends and health care professionals (when appropriate) as part of a care needs assessment. All of the information obtained should then be used to assist the home in deciding if the needs of the prospective resident can be met, including whether or not the staff have the skills to meet the individual needs of the person concerned. Only then should agreement be reached about the person's admission to the home.

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.

If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 7, 8, 9 and 10.

People have care plans in place but because these are incomplete and medication administration practices at the home are poor we are not confident that people have all of their care needs, including health care needs, fully met.

Evidence:

We looked at the care records for four people living or staying at the home. We noted that the three people living at the home permanently had care plans in place but the person having respite care as the home did not. People who have respite or temporary care at the home must have a full care needs assessment and care plan in place so that staff have the information they need to meet their needs.

The care plans that we saw reflected the areas in which the person concerned needed assistance with daily living tasks - the areas covered are not the same for each person. Two people had a care plan that covered mobility, personal hygiene, incontinence, medication and 'uphold faith and rights'. Another person had a care plan

Evidence:

that included personal care, social stimulation, 'uphold faith and rights', incontinence problems, food and diet and daily living plan. Care plans should address all of the areas identified in the comprehensive care needs assessment, and each section of the care plan should be accompanied by an appropriate risk assessment.

We noted that some people had needs around pressure care, nutrition, the risk of falls and challenging behaviour but that these areas were not necessarily accompanied by an appropriate risk assessment. Although some people did not have risk assessments in place for pressure care and continence care when this was an identified areas of need, we noted that appropriate pressure care equipment and continence supplies had been obtained for them.

There are some risk assessments in place. All three people who permanently live at the home had a moving and handling assessment in place that recorded whether the person is weight bearing, the need for assistance from one or two staff for transfers and the use of mobility equipment. In addition to this, each person had one individual risk assessment in place; these were for 'the possibility of falling due to wandering', 'displaying aggression' and 'isolation from social interaction leading to low mood'. All of the risk assessments recorded control measures to try to minimise the risk or to inform staff of the action to take should a person's behaviour deteriorate. One of these risk assessments was written on 17/9/08 and it recorded that the risk would be reviewed every six months - there was no evidence that a review had taken place.

The care plan for one person recorded that they had been provided with a bed rail. We did not see any evidence of a risk assessment for the use of a bed rail or any general information in the home about the use of bed rails, including the guidance issued by the Medicines and Health Care Regulatory Agency (MHRA). The responsible person must ensure that this guidance is being followed.

A monthly review of each care plan area has been recorded but on all but one occasion the entries were 'no change'. However, when we looked at other information in care plans it was evident that there had been changes to a person's physical and emotional care needs, such as changes in medication, changes in behaviour, changes concerning family members and hospital admissions. All changes in a person's care needs must be clearly recorded in care plans to ensure that staff are working with up to date information and that people receive the care they need.

We noted that daily diary entries are recorded in a large book; one book is used each month. When a new book is started the old book is filed away so the information is not readily available to staff. This is outdated practice, is not individualised and does not

Evidence:

protect a person's confidentiality. This information is part of a person's individual record of care and should be stored with other care planning information.

We saw that one person had had an annual review meeting to discuss their plan of care. It was agreed at this meeting that some areas of the care plan would be rewritten and forwarded to the care coordinator from Social Services who had organised the review. A very brief entry had been made on the care plan to record one of the areas identified as needing to change but there is no record of an updated care plan being sent to Social Services. One outcome of the recent safeguarding investigation was that, although staff were aware of this change to the person's care plan, they did not follow it. The other two care plans seen did not include any information to indicate that an annual review of the care plan had taken place.

There is a record in care plans of contact with health and social care professionals. This records the reason for the contact and the outcome. Correspondence was seen from speech and language therapists and other health care professionals and we saw evidence of meetings that had taken place with psychiatrists, community psychiatric nurses and other health care professionals to discuss health care issues.

A Care Quality Commission pharmacy inspector undertook a random inspection as a result of issues being raised during a safeguarding investigation. The outcome was as follows:

'We found no direct evidence of incorrect administration of medicines but the lack of detailed medication receipt, administration and disposal records means it is not possible to be certain that people living in the home always received their prescribed medicines exactly as directed. Medication management processes in the home do not follow best practice and we found a lack of awareness of current professional guidance documents.

We found that the office containing the medication store room was unlocked and that the keys to the store room had been left in the door. A notice on the store room door identified the contents of the room as medicines. The controlled drugs cupboard does not meet current safe custody requirements and it was not attached to the wall of the store room. The controlled drugs register was unsuitable for use and records of controlled drugs administration and handling in the home do not meet current guidelines. No thermometer was available for staff to check the temperature of the store room. No medication fridge was available and we found one container of medicines in the store room clearly labelled 'Store in a refrigerator'. All medicines must be stored securely at temperatures recommended by the manufacturer. No other

Evidence:

items or personal staff belongings should be stored with medicines and access to the medication store room must be restricted at all times to authorised staff only. This will help staff to know medicines are safe to use when needed. We also found 16 containers of medicines belonging to people no longer living at the home or not able to be identified as the pharmacy label had been removed. Retaining unwanted medicines alongside medicines in current use is not safe as mistakes may be made. A further three containers had hand written labels attached. Staff told us that one of these had been provided by a family member but was not sure where the other two had come from. So that staff know they are safe to use, medicines must only be given to people from containers provided and labelled by a pharmacy or dispensing doctor's practice.

We were told that records of medicines received and disposed of are not routinely kept in the home and we found that no such quantities were written on the MARs each month. We were also told that the home had been advised to destroy unwanted medicines in the on-site incinerator. This practice is in breach of current environmental waste regulations and staff immediately agreed to return all unwanted medicines to the supplying pharmacy in future.

When we examined the 20 current MARs for accuracy and completeness we found no staff signature list making it difficult to know who had made individual records on the MARs. Each person's MARs were not separated from others by dividers and no photographs or additional identifying information was provided. This increases the risk of a mistake being made by giving a medicine to the wrong person. We found no additional information about when and how people living in the home prefer to receive their medicines or about how to give medicines prescribed 'when required'. Such information helps staff to give medicines consistently and correctly and also helps to reduce the risk of refusals or omissions. Where administration gaps or omission codes were seen on the MARs, no additional information was found explaining why these doese hadn't been given. Eight MARs contained 16 new hand written entries which had not been signed, dated or witnessed and which lacked essential information. Seven MARs contained 10 handwritten changes to directions which had not been signed, dated or witnessed and on questioning staff, the original record of the reason for these changes could not be produced. For example, dose changes of one person's medicine made after hospital blood tests were not confirmed in writing so staff accepted verbal information from a family member when updating the MAR. Another person's MAR contained hand written changes to three medicines made by staff following telepone conversations with a hospital consultant. A member of staff relied on a verbal report of these conversations when told to make the changes. Hand written entries and changes to MARs must be clear, detailed and complete and safe arrangements must be made to ensure staff know the reasons for the changes. A second person should always

Evidence:

check these entries for accuracy so that all staff follow the changes on the MARs correctly.

On questioning, no records of checks of medication record keeping or audits of quanitites of medicines remaining could be produced. The lack of records of quantities of medicines received and retained each month means that it is very difficult to prove that all medicines are being given correctly as directed.

Staff told us that they were last trained in safe medication practice 'several years ago' but that updates were planned later this year. The home's medication policy and procedure documents should be updated to reflect current best practice. Staff were also unaware of professional best pratice guidance published by the Royal Pharmaceutical Society and the Care Quality Commission. Staff agreed to obtain these documents and to seek support from the local NHS medicines management team. Having well trained up to date staff helps to reduce the risk of medication errors'.

The pharmacy inspector made five requirements and five recommendations in the random inspection report. The requirement for all medicines to be stored securely at temperatures recommended by the manufacturer has now been met; medication is stored in a locked petty cash box in the kitchen fridge and fridge temperatures are taken and recorded daily. A thermometer has been purchased for use in the medication store room to ensure that medication is stored at the correct temperature.

Some progress has been made towards meeting the other four requirements, for example, a controlled drugs cabinet and book have been ordered and staff have started to record medication that is returned to the pharmacy. We noted that written records are now kept of any changes to the level of Warferin that should be administered for the individual concerned. The recommendations remain outstanding, and again, some progress has been made towards meeting these.

We observed the administration of medication on the day of this site visit. We noted that the senior carer responsible for the administration of medication used new disposable gloves for each person requiring assistance with medication. Medication was taken from the Nomad pack to the staff member's hand and then on to a spoon to be given to the service users concerned. We noted that people already had a drink with which to take their medication and that MARs were not signed until people had been seen to take their medication.

We were told by staff on duty that only the senior carer and team leaders have responsibility for administering medication but that staff who have completed NVQ

Evidence:

Level 2 in Care can assist with this process. On questioning, we were told that night staff do not have access to the medication store room. The MARs are kept in the staff room overnight so that, if anyone had to be admitted to hospital, staff would be able to photocopy their MAR to take with them. In addition to this, if someone needs pain relief during the night staff would be able to check the amount of medication that they have taken during the day and assess whether it is safe for them to have more. Because night staff do not have access to prescribed medication, a small amount of pain relief medication and 'homely' remedies are stored in the staff room so that they could be given by night staff. Staff told us that any medication given in this way is recorded on the MAR but ideally, a member of night staff should be able to access the medication store room so that people could be given their own prescribed medication; this reduces the risk of errors being made.

We noted that the code 'R' should be used on MARs when someone refuses or does not need medication but that, on occasions, some staff are recording 'X' instead. Codes recorded on MARs should be used consistently to avoid confusion.

Some people have a single room so they are able to see people in private, and there are private areas of the home where people are able to meet with family and friends and health care professionals. A new treatment room (that is also used as a sensory room) had been provided - this has been equipped so that district nurses can use the room to undertake nursing tasks. However, issues raised during a recent safeguarding investigation about a person's freedom to choose whether or not to stay in their own room or mix with others lead us to believe that, on some occasions, a person's right to privacy and dignity is not upheld.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 12, 13, 14 and 15.

People enjoy some social activities, visitors are usually made welcome at the home and people have good wholesome food. Because there is little information recorded about a person's previous lifestyle it is difficult to ascertain if they continue to live their chosen lifestyle.

Evidence:

None of the care records we saw on the day of the site visit included information about a person's life history or previous lifestyle, so there was no information to guide staff about what the person's interests were. Only one person had 'social stimulation' identified as an area of care in their individual care plan and monthly reviews always recorded 'no change'. We checked the daily diary sheets for each person living at the home. These record a person's mood, assistance with personal care, any visitors seen and food/fluid intake, although only in brief detail.

Key worker records were also seen - key workers do spend quality time with people but this tends to consist of chatting whilst undertaking personal care tasks rather than

Evidence:

spending one to one time undertaking meaningful activities.

On the day of the site visit someone visited the home to run a 'Movement, Music and Memory' session. These take place weekly and we saw that they were enjoyed by the people taking part and that the facilitator had a good rapport with them. The facilitator writes a report on each person's participation and progress; these were seen in care records.

We saw that the hairdresser was also at the home on the day of the site visit and that people enjoyed this provision.

On the day of the site visit we saw several visitors at the home and relatives have told us that they are able to visit at any time. However, we have received a complaint from one family whose visits were restricted - this is currently being investigated by the safeguarding adults team. Visits must only be restricted if this is the express wish of the person living at the home.

There is information available in the home about available advocacy services so that people are able to access this information independently. There have also been Best Interest meetings held at the home to assist with decision making for people who do not have the capacity to make some of their own decisions.

The menu was displayed in the hall area outside the dining room - this recorded the main meal at lunchtime plus an alternative option for diabetics. There was no option offered to other people, although there were two puddings available to choose from. The menu recorded that there is ample choice available at breakfast time and tea-time. Staff told us that people are provided with an alternative meal if they do not like the main meal on offer, but people should be offered a true choice of main meal at lunchtimes.

We saw the serving of lunch and noted that the meal looked appetising, although people were given very large portions. People were assisted appropriately to eat their meals and staff encouraged those who were reluctant to eat. Most people chose to eat in the dining room and this was promoted as a social occasion. Those people who did not wish to use the dining room were served their meal on a small individual table in the lounge.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People's legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 16 and 18.

There are complaints policies and procedures in place but we are not confident that people living a the home and others are encouraged to use them. Staff have not had training on safeguarding adults from abuse and there is a lack of understanding of whistle blowing policies and procedures within the home that could leave people at risk of harm.

Evidence:

The complaints policies and procedures are displayed in the home and are also recorded in the home's statement of purpose; a copy of this was sent to the CQC as part of the new registration procedure for the use of an additional bedroom to be agreed.

We were told that there is no log book in place to record complaints made to the home. However, copies of complaints received are retained and these were seen by the inspector. We noted that they were all from staff about other staff members or about care practices at the home. A record had been made of the action taken by the manager to address these complaints. People living at the home and others should be encouraged to use the complaints procedure, as this is seen as a way to improve the overall quality of the service provided.

Evidence:

It is good practice to record all complaints received in a log book so that practices around the recording and investigation of complaints can be monitored and analysed. In addition to this, it is useful to record any concerns or 'niggles' expressed by people living at the home or others. Dealing with these shows that staff are listening to people's concerns and acting upon them to improve the overall service provided by the home. Since the key inspection the secretary working at the home has sent us a copy of a complaints log that they intend to use in the future. In addition to this, they have devised a form to record all Regulation 37 notifications that are sent to the CQC and all safeguarding alerts that are sent to the local authority.

We asked to see the training and development plan so that we could ascertain how many staff had undertaken training on safeguarding adults from abuse. We were told that there is no training and development plan in place but we were provided with these figures at a later date. This evidenced that only one member of staff out of a staff group of 27 care staff and two catering staff had undertaken this training. We noted that eleven staff have completed the NVQ Level 2 in Care award - they may have studied abuse as part of this training. However, this does not provide sufficient evidence that staff have received and understood information about safeguarding adults from abuse and leaves people living at the home at risk of harm.

In addition to this, a serious safeguarding referral was recently received by East Riding of Yorkshire Council and it became apparent at the start of the investigation by the Police and Social Services that the people responsible for operating the home did not understand whistle blowing policies and procedures or disciplinary policies and procedures.

The investigation undertaken by the Police and Social Services identified several issues that had occurred between service users that should have been referred to the local authority under safeguarding protocols but had not been. This left us with a lack of confidence about how safeguarding issues are dealt with at the home.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 19, 21 and 26.

People live in a home that is clean, comfortable and well-maintained and staff follow good hygiene practices that protect people from the risk of cross infection.

Evidence:

We toured the premises as part of this key inspection. We found that the layout of the home is suitable for its stated purpose; it is accessible, safe and well-maintained. There is no routine maintenance programme in place but there is a handyman employed for 4 hours per day, Monday to Thursday. Staff leave the handyman a note informing him of repairs that need doing but these are not currently recorded - we advised that these requests should be recorded and then the handyman could sign the book when tasks have been completed. This would provide a record of the maintenance work that has been carried out at the home. In addition to this, there should be a planned maintenance programme in place that records future plans for redecoration and refurbishment, and plans for replacing equipment; this would evidence future planning and financial viability.

We noted that the floor in one bedroom was uneven and we were concerned that this could create a trip hazard. The registered person agreed to take action to rectify this

Evidence:

immediately.

The home is decorated and furnished in a homely way. The large conservatory to the front of the property allows people ample access to sunlight and views of the open countryside. We were told that they plan to create a courtyard area to the side of the property where people can sit out safely and maybe do a little gardening themselves.

A new treatment room/sensory room has been created and this provides a hygienic and comfortable area for people to see health care professionals or to spend time relaxing away from other people living at the home. This room is well equipped and furnished.

We were told that the home has now installed another jacuzzi bath, following requests from people living at the home. A shower cubicle has also been installed in one of the bathrooms, so people now have the choice of having a bath or a shower. We noted that bathrooms provide ample space for people to be assisted with having a bath or a shower; there is sufficient room for mobility equipment to be used and for staff to assist.

We saw that the home was clean and that there were no unpleasant odours on the day of the site visit. Disinfecting gel was available in the entrance area and in toilet facilities and we saw that staff follow good hygiene practices. The training and development plan that was forwarded to us following the day of the key inspection evidences that four care staff and one cook have attended training on infection control; we recommend that all staff attend training on this topic to ensure that everyone understands the importance of following good hygiene practices. The secretary told us that this topic is included in induction training. However, some staff have worked at the home for a long time so refresher training is now needed.

We saw the laundry facilities at the home and found these to be satisfactory; the washing machine has a sluice facility. The laundry room is not close to areas where food is stored, prepared, cooked or eaten and there are hand washing facilities for staff. Walls and floors are impermeable and easily cleanable.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 27, 28, 29 and 30.

People are supported by sufficient numbers of staff and most staff have been recruited in a safe way. Staff receive appropriate induction training but, because they don't receive ongoing training, there is a risk that their skills and knowledge are not kept up to date and this could result in people not receiving the care they need.

Evidence:

We saw the staff rota and noted that it records the role of each member of staff on duty. On the day of the site visit there were senior carers, carers, domestic assistants and a cook on duty; in addition to this, a director of the company was also on duty. There is a cook on duty every day and domestic staff on duty every day apart from Sunday. This enables care staff to concentrate on care duties and also reduces the risk of cross infection by staff not carrying out domestic and catering duties as well as care duties.

Eleven of the 27 care staff have achieved NVQ Level 2 in Care; training towards this award should continue until at least 50% of care staff have achieved this award. One of these people has also achieved NVQ Level 3 in Care and another member of staff is working towards this award.

Evidence:

We saw the induction training records for two new members of staff. These evidenced that staff start induction training that meets Skills for Care requirements when they first commence work at the home. We were told that this training includes information about infection control, moving and handling and food hygiene. However, we noted that staff do not continue to have refresher training on these topics. One person had induction training in 2002 and another had this training in 2005 and there is no record of any training that they have undertaken since that time. Records show that some people have not completed induction training - it may be that they have worked at the home for a long time, prior to the requirement for formal induction training to be undertaken.

There is currently no evidence that staff have three paid days training per year. We saw a notice on display informing staff of some forthcoming training - this included dementia awareness, palliative care, nutrition and health, safeguarding adults, health and safegy, diversity and equality and communication. The home has purchased some training DVD's but there are no records available about how this resource has been used. There are some individual training records in staff files but none of these record recent training apart from attendance at a challenging behaviour workshop on 17/11/09.

There is no training and development plan in place at the home (although one was produced and forwarded to us following the day of the site visit); this recorded that most staff have not had moving and handling training or food hygiene training, that only five staff have had training on infection control and that only one person has done training on safeguarding adults from abuse. This leaves people living at the home at serious risk of harm due to the out of date training of staff members.

We looked at the recruitment records for two new members of staff. These included a completed application form that recorded the persons employment history, their experience and relevant training, a criminal conviction declaration and the name of two referees. Notes are made about interview questions and responses and evidence of the person's identification documents are retained. One of these people had only one written reference in place. Prospective employees must have all safety checks in place prior to commencing work at the home, i.e. an Independent Safeguarding Authority (ISA) Adult First check and two written references to evidence that they are considered suitable to work with vulnerable adults. In addition to this, reference form must be clear, i.e. they should record the date and signature of the referee and the date that the reference was received at the home.

Evidence:

When people start work following receipt of an ISA first check but before their Criminal Records Bureau (CRB) check has been received they must work under supervision and these supervision arrangements must be recorded - we did not see any evidence of this for the two new members of staff, although the director did tell us that new staff always work as an extra member of staff on the rota until a satisfactory CRB check has been received.

In staff records we saw evidence of people being disciplined on several occasions for similar offences. One person was having a trial period in a more senior position when they were disciplined but still allowed to continue with their trial period and then promotion. This led us to believe that the home's disciplinary procedures are not followed on occasions.

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

We looked at outcomes for Standards 31, 35, 36 and 38

Evidence:

The registered manager was not working at the home on the day of the inspection. As an interim measure, a director of the company and a senior carer are sharing management responsibilities.

The safeguarding investigation raised concerns about policies and procedures in place at the home not being adhered to. There must be monitoring systems in place to ensure that all policies and procedures at the home are understood, followed and implemented by staff. There is a recognition by the responsible persons that medication polices, practices and procedures in place at the home have not been adhered to and that there has been a lack of understanding about safeguarding protocols. The responsible persons have started to address some of the shortfalls that were identified prior to this key inspection - a controlled drugs cabinet and controlled drugs book have been ordered, medication is now stored at the correct temperature

Evidence:

and a start has been made on downloading information on the administration of medication from the CQC website - evidence of this progress was seen on the day of the site visit.

There is a quality assurance system in place at the home. We were told that the home continues to distribute surveys as part of their quality monitoring process and that staff meetings are held three or four times per year; this was confirmed by the staff that we spoke to. The director told us that there used to be a resident committee at the home and that they used to hold resident meetings, but due to people's capabilities, these were no longer feasible. This is not an effective quality assurance system as it has not picked up any of the areas that need improvement that have been identified in this inspection report.

The director told us that the home does not hold any monies on behalf of people living at the home. Relatives and respresentatives who manage the financial affairs of people are sent an account for any monies owed for hairdressing, chiropody etc. Two people have small amounts of money that they hold themselves; we suggested that these people could be provided with a small cash box in their bedroom so that monies can be held safely. People should be provided with a lockable facility in their bedroom so that they are able to hold money, valuables and medication safely.

We looked at a sample of health and safety documentation on the day of the site visit. The fire alarm system and emergency lighting had been checked by a competent person in November 2009. Fire training includes a fire drill; this takes place annually and the most recent session was held in January 2010. There is a fire risk assessment in place that was reviewed in May 2009. This records that weekly in-house tests of the fire alarm system should take place but we noted that these are not consistent. The fire alarm system was serviced on 3/11/09, the fire alarm sounded on 20/1/10 and in-house tests had taken place on 2/2/10 and 11/2/10 - these must take place on a weekly basis as recorded. A Fire Officer visited the premises on 12/11/09 and wrote to the home following their visit to confirm that the home was broadly compliant but that some work needed to take place on fire doors.

The lift and electical appliances had been serviced appropriately. Weekly room checks take place so that any health and safety issues can be idenfied and rectified. There is no mains gas supply to the home; the kitchen range is powered by calor gas.

Some health and safety training takes place at the home but records evidence that much of this training is out of date. Only two people have done training on food hygiene, five people have done trainng on infection control and four people have done

Evidence:

training on moving and handling. This leaves people living at the home and staff at the risk of harm by staff using poor moving and handling techniques and by following poor hygiene practices. All staff must have training that equips them with the knowledge and skills to carry out their role effectively and safely.

Are there any outstanding requirements from the last inspection?				
	Yes	☑	No	☐

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13	Controlled drugs must be stored securely and records of receipt, administration and return must be made in accordance with current regulations and guidelines. This will provide the necessary additional protection against loss or diversion of these medicines.	31/03/2010
2	9	13	Arrangements must be made to ensure all medicines are administered as directed and that care plans include relevant instructions for staff in this respect. This will help to make sure that staff administer all prescribed medicines correctly as and when needed.	31/03/2010
3	9	13	Arrangements must be made to ensure that medication records are accurately completed and maintained in a timely manner including those for all medicines received, administered and leaving the home. This will help to show that medicines are being used correctly as directed.	31/03/2010

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
4	9	18	Arrangements must be made to ensure that all staff authorised to handle and give medicines have received relevant update training and that their practice is then checked regularly. This will make sure staff are suitably qualified and competent to give medicines safely.	30/04/2010

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	People must have a full care needs assessment prior to their admission to the home. This must cover all of the person's care needs. This is to ensure that only people whose assessed needs can be met by staff working at the home and by the home environment are offered a place.	31/03/2010
2	7	17	Daily records must be included with other care planning documentation. This is needed so that there is a complete and up to date record of the care provided for each person, including any changes to their care needs.	31/03/2010
3	7	15	People having respite care at the home must have a full care needs assessment and care plan in place.	31/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			This is needed so that staff have the information they need to meet the person's individual assessed needs.	
4	7	15	People must have a full care plan in place that records how their assessed needs will be met by staff. Care plans must be personalised and must include information about a person's chosen lifestyle. This is to ensure that people continue to live their chosen lifestyle with support from staff.	31/03/2010
5	8	15	Care plans must include appropriate risk assessments such as those for pressure care, nutrition, behaviour and falls. This is to ensure that the risks associated with each area of care identified in care plans has been measured, and that staff know how to minimise any risks associated with a person's care.	30/04/2010
6	8	13	The registered person must ensure that they are working to the guidelines issues by the MHRA on the use of bedrails.	31/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			This is to ensure the safety of any person living at the home who uses a bed rail.	
7	9	13	Arrangements must be made to ensure all medicines are administered as directed and that care plans include relevant instructions for staff in this respect. This will help to make sure that staff administer all prescribed medicines correctly as and when needed.	31/03/2010
8	9	13	Controlled drugs must be stored securely and records of receipt, administration and return must be made in accordance with current regulations and guidelines. This will provide the necessary additional protection against loss or diversion of these medicines.	31/03/2010
9	9	13	Arrangements must be made to ensure that all staff authorised to handle and give medicines have received relevant update training and that their practice is then checked regularly.	31/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			This will make sure staff are suitably qualified and competent to give medicines safely.	
10	9	13	Arrangements must be made to ensure that medication records are accurately completed and maintained in a timely manner including those for all medicines received, administered and leaving the home. This will help to show that medicines are being used correctly as directed.	31/03/2010
11	13	16	People must be able to visit the home at any time unless the service user has expressed a wish not to see them. Where someone lacks capacity to make this decision, a review or Best Interest meeting should be held so that a decision can be made by all parties involved. This is to ensure that the wishes of the individual concerned are understood and followed.	30/04/2010
12	18	13	There must be evidence that staff and responsible persons understand the	30/04/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			policies and procedures in place on safeguarding adults from abuse, including whistle blowing. This is needed to ensure that people living at the home are protected from the risk of harm.	
13	26	13	All staff must have training on the control of infection. This is needed to evidence that all staff understand the importance of following good hygiene practices.	31/05/2010
14	29	19	There must be two written references in place prior to people commencing work at the home. This is to ensure that only people considered suitable to work with vulnerable people are employed.	31/03/2010
15	30	18	There must be a training programme in place that provides ongoing training for staff on topics that include infection control, safeguarding adults from abuse, dementia awareness, moving and handling, food hygiene, health and safety and first aid. This is to ensure that staff	31/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			have the skills needed to meet the assessed needs of the people living at the home.	
16	31	10	Management arrangements at the home must be robust; policies and procedures must be followed by all staff and there must be monitoring systems in place to evidence this. It is not sufficient to have policies and procedures in place. The responsible persons must ensure that these are adhered to by managers and staff.	30/04/2010
17	38	18	Staff must have training on health and safety topics such as first aid, health and safety, food hygiene, infection control and moving and handling. This provides staff with the skills and knowledge they need to carry out their role safely.	31/05/2010
18	38	23	Weekly in-house tests of the fire alarm system must take place consistently. People are at risk of harm from a fire breaking out at the home if the fire alarm system is not tested on a	12/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			regular basis to ensure that it is working correctly.	

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	7	Monthly reviews of care plans should take into consideration all events of the past month - care plans should be adjusted accordingly to ensure that staff are working with up to date information.
2	9	Hand written MAR entries and changes should be checked for completeness and accuracy.
3	9	Regular checks of medicines kept in the home, medication record keeping and staff practice should be made and recorded.
4	9	People's own choices about when and how they prefer to receive their medicines should be recorded and reviewed regularly.
5	9	The medication policy and procedure documents should be updated to reflect current best practice.
6	9	Identification photographs and personal information should be permanently fixed to MAR chart dividers.
7	9	Night staff should have access to a person's prescribed medication so that they do not have to use spare supplies of medication held by the home. This would reduce the risk of errors being made.
8	12	Care plans should include information about a person's previous lifestyle and life history so that staff have information that helps them to ensure that a person's lifestyle choices can be met.
9	12	Key workers should spend meaningful one to one time with people; this should not include time spent with people whilst assisting with personal care tasks.
10	15	There should be a true choice of lunch offered every mealtime.

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
11	16	Any complaints received by the home should be recorded in a complaints log. This enables any complaints made to be monitored and analysed, and may lead to improvements being made to the service provided.
12	16	There should be evidence that people are encouraged and supported to use complaints policies and procedures at the home. It is also good practice to record concerns and 'niggles'; this could ultimately lead to improvements in the service provided.
13	19	There is an uneven floor in one bedroom that could create a trip hazard. This should be made safe.
14	19	There should be a programme of routine maintenance in place to evidence future plannng and financial viability.
15	28	Staff should continue to work towards NVQ Level 2 in Care so that the home has a minimum of 50% of their care staff who have achieved this award.
16	29	The home should adhere to it's own disciplinary procedures to ensure that the staff employed to work there are considered to be fit to carry out their role.
17	29	People employed after an ISA first check is received but before a CRB check is received should only work under supervision, and these supervision arrangements must be recorded.
18	30	There should be evidence that staff have had three paid days training per year.
19	30	There should be a training and development plan in place that records all of the training needs and achievements of the staff group. This should include the date that training was undertaken so that the need for refresher training is identified.
20	33	There should be a robust and effective quality assurance system in place at the home that gives people the opportunity to affect the way in which the home is operated and encourages participation.
21	35	People should be provided with a lockable facility in their bedroom so that they can hold money, valuables and medication safely.

Helpline:

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