Review of compliance

Eastfield Farm Residential Home Limited Eastfield Farm Residential Home Limited	
Region:	Yorkshire & Humberside
Location address:	Eastfield Farm Southside Road Halsham Hull East Riding of Yorkshire HU12 0BP
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Eastfield Farm Residential Home is a care home that provides care and accommodation for older people, including those with dementia related conditions. There are three living rooms, a dining room and a treatment room on the first floor. Bedroom accommodation is provided on both the ground and first floors.

	The home is situated next to a working farm with views over open countryside and there is ample parking space for staff and visitors to the home.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Eastfield Farm Residential Home Limited was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 June 2011 and observed how people were being cared for.

What people told us

We did not speak to residents on the day of our visit. We conducted a SOFI inspection; this is a way of inspecting that is based on dementia care mapping. The inspector sits with a group of residents and observes the interaction between residents/residents and residents/staff. This type of inspection is designed to observe the experiences of people living at the home who are not able to tell us verbally how they feel about the service they receive.

What we found about the standards we reviewed and how well Eastfield Farm Residential Home Limited was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were able to make decisions about their day to day lives and had their privacy, dignity and independence respected by staff.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

There was evidence of unsafe practice when medication was being administered and this could cause harm or distress for people living at the home.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we found that improvements were needed for the following essential standards:

- Outcome 07: People should be protected from abuse and staff should respect their human rights

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
- Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
- Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We did not speak directly to people living at the home about this outcome.

Other evidence
The Care Quality Commission (CQC) received information from a whistle blower about practices at the home. This suggested that, on occasions, people living at the home were made to do things that they did not want to do by staff.

On the day of our visit to the home we conducted a short observational framework inspection (SOFI) so that we could observe the interaction between residents and staff. We observed three people who were not able to communicate verbally due to various degrees of dementia and their interaction with the care workers on duty. We saw that staff interacted with these people in a way that engaged them in their surroundings. They made eye contact with the residents, smiled at the residents when the walked past them and encouraged interaction. One member of staff was not as skilled as the others at this non verbal communication but did attempt to interact with residents.

One person had been helped out of their lounge chair and assisted by a care worker to walk to the toilet. They then returned to their lounge chair. A little while later, when asked if they would like to go to the dining room for lunch, the resident refused. The

member of staff tried to persuade the person to stand; they remained calm and spoke to the resident in a reassuring manner. The resident was still reluctant to move and another member of staff asked them to come to the dining room for lunch. Eventually the resident was assisted to their feet and then appeared to be quite happy to walk with a care worker to the dining room. This was done in a dignified and respectful manner.

We observed the three residents over lunchtime and saw that they reacted to the actions (noise and movement) of both other residents and staff. One person made attempts to join in the conversation with the other people sitting at their table. One person needed a lot of encouragement to eat their meal, as they could only concentrate for short periods of time. The care worker (a different one to those referred to previously) assisted the resident in a calm and patient manner whilst encouraging them to eat and drink; this was carried out on a one to one basis.

We saw that people were offered a choice of meal and were asked what they would like to drink from a variety of choices. If they did not understand the verbal communication, they were shown the items of food and drink to enable them to make a choice.

Our judgement
People were able to make decisions about their day to day lives and had their privacy, dignity and independence respected by staff.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak directly to people living at the home about this outcome.

Other evidence
The CQC received information from a whistle blower alleging that a member of staff was giving out medication earlier than stated on the medication administration record (MAR) sheet.

We discussed this with the manager and one of the providers. They told us that a senior carer with responsibility for the administration of medication had been concerned that a resident had been prescribed medication to take at 8.00 pm but usually went to bed at 7.30 pm. Contact had been made with the GP, who had agreed that the resident could be given the medication half an hour earlier. This contact with the GP had been recorded. The manager told us that they were aware of the need to have appropriate gaps in between the time that medication was administered and this had been taken into consideration.

On the day of this visit to the home we saw that the care worker responsible for the administration of medication took some medication into the dining room and left it in a pot next to the person that it was intended for. They did not wait to check that the resident had taken the medication. This is not safe practice, as someone else could have taken the medication by mistake, causing physical harm or distress.

We previously visited the home on the 23rd May 2011 and on that occasion we saw evidence that all of the people with responsibility for the administration of medication

had undertaken appropriate training. In the report of that inspection we recorded, 'People received their medicines at the times they needed them and in a safe way, although more care needed to be taken with recording on medication administration record charts'.

During our last visit to the home we saw evidence that staff were in the process of undertaking training on equality and diversity. The manager told us that he intended to arrange training for staff on 'dignity' when all mandatory training had been completed.

Our judgement
There was evidence of unsafe practice when medication was being administered and this could cause harm or distress for people living at the home.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: There was evidence of unsafe practice when medication was being administered and this could cause harm or distress for people living at the home.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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