Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Cornfields

Roman Road, Winklebury, Basingstoke, RG23 8HD

Tel: 01256844603

Date of Inspection: 31 January 2014

Date of Publication: February 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	Liaise Loddon Limited
Registered Manager	Mr. Philip Tala
Overview of the service	Cornfields is a care home which provides personal care and accommodation for three young adults who have a learning disability.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with carers and / or family members and talked with staff.

What people told us and what we found

The people who use the service were not able to verbally communicate with us. Therefore we spent time looking at care records, talking to staff and observing interactions with the staff and the people using the service to determine how their needs were being met and to understand their individual experience of the service. We spoke with people's representatives to understand their views about the quality of care provided at Cornfields.

The provider told us that people who use the service were supported to reach as much independence as possible. Representatives of people who use the service told us that the provider helped their relatives to make choices and that their relatives were happy, content and had an active social life. We evidenced that the provider used a variety of methods to ensure that people who use the service were fully involved and where possible to, were able to consent to the care, support and treatment they received. Communication methods used by the provider included the use of makaton, photographs, picture boards and visual aids.

One representative of person who uses the service told us that "the staff at Cornfields engages my relative as much as possible in making decisions and anything that is decided for them is fully discussed with me". Another representative told us that they were involved in all decisions about their relative.

The premises were clean and tidy and bedrooms decorated to the individual style of people using the service. Safety equipment was in place and had been tested regularly. Evacuation plans for each resident were recorded and on their personal file. Risks to people living at the premises had been fully assessed and measures put in place to ensure their safety.

We found that medication was stored securely and its administration was recorded and monitored appropriately. Regular audits were undertaken to ensure that staff were complying with the provider's medication policy.

The training of staff was of a good standard and met the needs of people using the

service. The provider supported the ongoing training and development needs of staff. The representatives we spoke with were very complimentary of the training provided by the provider. One representative told us "staff are trained to meet the very complex and specific needs of my relative and this means they receive fantastic care".

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Through a process called pathway tracking we looked at the care records of two people who use the service. From the records we looked at we saw that the choices of people using the service were recorded on their personal records.

The people who use the service had been assessed as lacking capacity to make some important choices about their care and treatment and this was fully recorded in their care records.

There was evidence that people's representatives and been involved in making important decisions as had other professionals including the person's social worker psychiatrist, neurologist and psychologist and this was fully recorded in the records we looked at.

The staff we spoke with had received equality and diversity training and were able to tell us how they assess and treat people individually and always treated them with dignity and respect. Staff also explained how they assessed each individual goals that what they could aspire to and achieve. New goals were established at each care review and were monitored weekly to determine what had been achieved. A representative of person who uses the service told us "the staff respect my relative and involve them in all aspects of their care". Another representative told us that their relative becomes easily distressed and staff respected this and made changes to the service to reduce their stress and anxiety levels.

In the care records we looked at we saw that each person had a comprehensive assessment, care plan and review of their care on their file. The provider had a person centred feedback form that staff could complete and it detailed any improvements that could be made to the care and treatment people received that could improve their quality of life. In the reviews of people's care that we looked at and in the minutes of team meetings, it was evident that ideas and suggestions had fed into people's reviews of their care.

There was evidence that support workers offered people choices about how they wanted to live their life. For example, the people who use the service engaged in a number of in-house and community activities however they were offered choice's about whether they wanted to continue to attend them and if they could not tell the worker, the person's representative was fully consulted.

The provider maintained a record of weekly activities and this detailed all activities offered to people using the service. We saw that there was plenty of choice of activities including walking, baking, maintaining the house, sensory stimulation and swimming. Each person also had an individual activity plan and community activities that people participated in were varied and planned around the needs of the individuals care and support needs.

The staff we spoke with told us that they supported people to be as independent as possible and they respected the choices and wishes of people using the service. For example, one person was very physically active and staff took the person out on regular walks to ensure that they had the physical activity they needed.
One member of staff told us "we treat people individually and do everything we can to ensure their needs and wishes are respected"

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Most of the people who use the service were not able to give consent to many aspects of their care and treatment. We looked at care records and spoke with staff and representatives to evidence how people were encouraged to make choices about the care they received.

We looked at the care records of two people who use the service. We found that decisions about care and treatment had been discussed with people's representatives and with social care and health professionals. Any decisions taken in the best interests of a person using the service was assessed and risks to the person identified. Significant decisions about medication and treatment were assessed as they arose and were made for specific situations.

One representative of person who uses the service told us that "the staff at Cornfields engage my relative as much as possible in making decisions and anything that is decided for them is fully discussed with me". Another representative told us that they were involved in all decisions about their relative.

Each person using the service had a communication plan on file. This meant that the provider had a plan that identified how staff could communicate with people to ensure that where they could make a decision they were enabled to do so. Staff used a variety of methods to gain consent from people including Makaton and photographs that people could point to, to indicate their preference. A support worker we spoke with told us "we assess people's choices by engaging with them, asking them what they would like and assessing their body language and gestures". Another support worker told us "we never do anything with the person without asking them first what they want".

The staff we spoke with had received training on the mental capacity act and were able to explain the principles of the act. A support worker we spoke with explained that they never assumed that the person lacked capacity to make any decisions. Staff told us that decisions made in the best interests of a person were made with multi-disciplinary professionals and in consultation with representatives.

Some of the people who use the service required restraint. This was because they could

cause injury or harm to themselves. If the need for restraint was assessed as necessary the provider ensured that multidisciplinary professionals and the person's representative were involved and agreed what form of restraint was needed to maintain the person's safety. Decisions were being kept under regular review to determine if there were least restrictive options that could be adopted. We spoke with the person's representative and they told us that they had been fully consulted and had agreed with the need to restrain their relative.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We looked at the care records of two people who use the service. We spoke to staff and relatives about the care they received and observed how staff interacted and delivered care and support.

People's care records were relevant to their individual needs, choices and abilities. Assessments and care plans included moving and handling, personal care, health needs, behaviour management and the likes and dislikes of the person. The plans also included what activities the person liked, communication needs, risks, safety and welfare.

We saw that representatives were involved in the reviews of assessment and care plans and also received copies of all reviews. One representative told us that they had received a copy of their relative's review undertaken in December 2013. Mental capacity and decision making was well documented on assessments. There was evidence of multi-disciplinary involvement in reviews of care plans including input from the person's social worker, psychologist, and neurologist and community nurses.

Every person had a photograph of themselves, that they had chosen, on the front of their file so that people could recognise their own care records. Most of the people who use the service had behaviour that was challenging and a separate assessment detailing what behaviours the person displayed and how to support them was well recorded on the care records that we looked at. There was detailed recording on how to identify if a person was becoming distressed and what de-escalation techniques should be adopted for the person.

We saw a clear policy for staff which outlined the assessment and care planning process and the persons support worker was fully involved in the assessment and review of the person. We saw that suggestions and ideas about the person's care made in the person centred care plan feedback forms were included in the person's care plan reviews. Each care plan that we saw included a risk assessment that outlined the procedure if the individual became ill or distressed.

The provider had recently made an adaptation to the property to accommodate the emerging needs of one person who uses the service who became upset at the constant

activity of another person. The impact of this transition was currently being evaluated by the provider to ensure that it met the needs of all people using the service. Representatives told us that the provider willingly makes adaptions to the property and service provision depending on the changing needs of people using the service. One representative told us "the care is person centred and the staff are always thriving to do things in the best interest of my relative". Another representative told us "my relative is treated with the upmost dignity and respect".

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We looked at the medication records for all people who use the service. We spoke with staff to establish how they monitored and administered medication and what training they had received to ensure that they administered medicines safely.

The provider employed a health education specialist and on the day of our visit we spoke with this member of staff. The staff member told us that it was their responsibility to ensure that staff understood people's health conditions and what medicine was prescribed for. On the day of our visit some staff were receiving refresher training on epilepsy and how to administer medication safely if a person had a seizure. The provider also engaged with a local pharmacist who provided updates on all new medicines.

We saw that medicines were stored appropriately in secure lockable cupboards. The provider had a medication administration policy MAR. MAR stands for Medication Administration Record. The provider also had a PRN policy which is a policy used for medication that is administered when a person presents with a defined intermittent or short-term condition therefore the medication is not given in regular or routine doses. From the records we looked at we saw that the provider audited the MAR charts and PRN every six weeks. We saw evidence that the provider had consulted with people's GP's and the pharmacist when it appeared that the person's health required a change of medication.

We looked at the medication administration records (MAR) of all the people who lived in the home. Each person's medication file had a photograph of them on the front of their file. The MAR chart also detailed what medication the person required, dosage instructions and administration times. All medicine that had been administered had been signed by the member of staff who had administered it.

We found there to be advice and notifications next to the medication cupboard outlining to staff the importance of maintaining good hygiene standards when administering medication. The notifications explained the importance of hand washing especially when administering eye drops and oral medication.

The provider used covert administration of medicines occasionally. Covert administration means that medicine is disguised in food or drink and is only likely to be necessary or

appropriate in the case of a person who actively refuses medicine but who is judged not to have the capacity to understand the consequences of their refusal. We saw evidence that the people's representatives and the GP's had been fully consulted on these decisions.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

On our visit we walked around the home and looked in all of the bedrooms, bathrooms, toilets, communal areas, the kitchen and dining room. All of the people using the service had their own bedroom and it was decorated in a style that they had chosen. One of the bedrooms had en-suite facilities and there were two bathrooms, one with a walk in shower and another with a bath with an overhead shower. All bathrooms had a secure deposit for sanitary waste.

The provider had locks fitted to the main entrance but staff explained that they took people who use the service out in the community if they requested to go out. Staff explained that doors needed to be secure as some of the people who use the service were known to try and leave the property and it would be unsafe for them go out without someone being with them. The risks to people using the service had been fully assessed and representatives and professionals consulted on this decision to have a locked door policy.

There were fire alarms fitted throughout the property. There were fire extinguishers in the downstairs hall, kitchen, and conservatory and on the first floor of the property. All the extinguishers had been tested recently. There was clear signage that detailed the evacuation point and plans for each person should there be a fire. Fire doors were fitted to the lounge and on every person's bedroom door.

The registered manager told us that fire safety checks took place weekly as did inspections of the property generally. All maintenance issues were reported depending on the risks any issues posed to people using the service and any repairs were dealt with promptly.

The people who use the service had challenging behaviour and because of this the provider had assessed the need to ensure that some electrical equipment did not pose risk of harm to people. For example, the television was in a locked, secure cabinet behind enforced glass. This was to minimise the risk of people using the service throwing or hitting the television.

All of the areas of the home that we looked at were clean and tidy. The kitchen was well organised and medication was secure. We observed one member of staff who did the

cooking and they were checking temperatures of food as to ensure that it remained safe to eat. We also observed the member of staff going to great lengths to ensure that work surfaces remained clean and free of any hazards to people using the service.

Throughout the premises we saw the health and safety general policy for staff to observe. The policy included the duty to maintain a safe working environment, safe equipment and the need to assess hazards to colleagues and people using the service.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

On the day of our inspection we spoke with the registered manager and support staff. We also spoke with a specialist support worker and the health education specialist who was visiting the premises on the day of our inspection to deliver refresher training on epilepsy management.

Staff told us that the provider supported their education, training and development needs well. The staff also told us that they valued the support in their development that was provided by the registered manager.

Many of the staff had a National Vocational Qualification (NVQ) in Health and Social Care. The completion of this had been supported by the provider. The registered manager told us that they took the development of their staff seriously and provided staff with all opportunities to ensure that they were adequately trained to care for people using the service. Training to staff included adult safeguarding, the mental capacity act, de-escalation techniques and communication with people who present challenging behaviour.

All new staff had a full induction and completion of the induction involved care mandatory training before staff could provide individual support to people using the service. The mandatory training programme took twelve weeks to complete and was assessed by the registered manager.

Staff had supervision every six to eight weeks but were able to raise concerns or issues as they came up, either individually or in team meetings. Staff meetings were held every week to discuss the individual needs of people using the service. Formal team meetings took place every eight weeks and from the records we looked at had been scheduled in the next year. At the meetings concerns about people using the service were discussed as well as general running of the home and staffing. The minutes of them were recorded and shared with the area manager and director of the training provider.

The appraisal policy included staff skills, individual leaning needs and performance. Staff told us that additional training was delivered if people who used the service had specific needs. Staff told us that they were encouraged to undertake all necessary training and this

was evidenced in the electronic records that the provider maintained.

The representatives we spoke with were very complimentary of the training provided to support workers. One representative told us "staff are trained to meet the very complex and specific needs of my relative and this means they receive fantastic care". Another representative told us "it is evident that the staff do the job because they care, they even change their shift to accommodate my relative's needs".

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk