Inspection Report

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

Low Fauld

Langrigg, Wigton, CA7 3LH

Tel: 01697320037

Date of Inspection: 05 August 2013

Date of Publication: September 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	West House
Registered Manager	Mr. David Evans
Overview of the service	Low Fauld is registered to provide personal care and accommodation for six people with learning disabilities and complex support needs. It is run by West House, a not for profit organisation which provides a range of services to people with learning disabilities in the Cumbria area. The accommodation consist of a large converted farmhouse located in a small village. The home has a vehicle to take people out. A team of support workers staff the house fulltime.
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 5 August 2013, 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 people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

People told us that they felt that their needs were being met by the staff working at Low Fauld. One person told us, "Staff help me go out and do things I like." People told us that they felt safe and were comfortable approaching staff with any concerns. They said that staff treated them well and they liked spending time talking with staff and going out with them.

We found that care planning was person centred, with people being involved in the development of their care and support. People were supported in a way that maximised their involvement and ensured that they had control over their lives, to the level of their ability. Each person we spoke with knew they had a key worker and said they spent time talking with them. People were focused on their plans having a good understanding of why they had been admitted to the home and the plans and goals for the future.

Staff were skilled at managing challenging behaviours and employed strategies to minimise risk and the need to use restraint or place other restrictions on people. This allowed people whose behaviour may be termed as challenging, to access the community and enhanced their quality of life as a result.

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

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.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Staff involved people by using information that was readily understandable and used different formats to engage people. Where some people's capacity to make decisions was impaired other people such as relatives, professionals and advocates were consulted. People were also made aware of additional support services including independent advocacy services. This was in addition to the organisations own support networks and focus groups set up to give channels of communication for feedback on the care received.

The use of healthcare passports meant that when a person was in hospital or being looked after by staff less familiar with them there were clear instructions on the care and treatment they wished to receive. This included key people to be contacted if any decisions about treatment where required.

We spoke with staff on how they implemented the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) within the service. A DoLs is a legal process that makes sure people's rights are protected and actions are only taken in people's best interest to keep them safe from harm. We saw evidence that each person's capacity to consent was being assessed and recorded by professionals qualified to do so. Multi disciplinary meetings were recorded and the rationale for making decisions in people's best interests was noted, along with family involvement and advocate input. The service demonstrated a good working knowledge of the legislation to ensure that people's rights were safeguarded. This was an area that was frequently reviewed in peoples care plans, and discussed at multi-disciplinary meetings. We noted that guardianship orders and community treatment orders were discussed as options to manage peoples rights in the least restrictive way. This was to ensure that they had the right balance between keeping a person safe and maintaining people's rights and independence.

Some people in the home occasionally needed physical restraint to keep themselves and others from harm. Staff placed an emphasis on using restraint as the last resort and used positive management plans to reduce the need for restraint. People had detailed

intervention plans that used de-escalation and distraction techniques. These were based on detailed analysis of behaviour to identify and hence avoid triggers leading to challenging incidents. An emphasis was placed on involving the person and gaining their consent prior to any restraint. This involved getting them to agree to the restraint methods being used to support them. This was recorded and the home could demonstrate through data collection that incidents of restraint for all people in the home had significantly decreased over time.

All of these measures ensured that Low Fauld placed an emphasis on gaining people's consent and this helped to minimise the risk of abuse and infringements on people's rights.

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 people's care plans and records and spoke with them and staff about how they were supported at Low Fauld. We observed lively and positive interactions between staff and people in the home which made for a relaxed and friendly atmosphere. We observed staff responding sensitively to people and picking up cues from body language when they needed assistance or reassurance. People told us how well they got on with the staff team, saying that the staff were always easy to talk to. One person told us, "I like to spend time with the staff and go out. They help me to do things I like."

We saw the policies and procedures for admitting new people to the home. These were comprehensive and gave staff clear instructions to follow when assessing and admitting a person to the service. Senior staff told us about the referral and admissions procedures for the service. They described how due to the complex nature of people's needs, particularly around behaviours that could challenge, there had been careful planning around compatibility issues and ensuring that the service had the skills to meet people's needs.

We saw that often the assessments of people had been carried out over many months, involving visits to the place they were living and gaining detailed information from the provider of that service. A multidisciplinary team was involved in the assessment of people prior to admission, and this was on-going in the home. We looked at the assessment records for three people to see if their needs were identified. These were detailed and clearly showed each person's needs. This had included identifying mental health needs and specialist needs of people with autism.

We spoke with staff about how care plans were developed in the service. They stated that person centred care plans were based on the detailed assessments completed as part of the admission procedure and by making use of previous knowledge from a variety of sources. We saw that people were receiving individualised care that was planned with the help of a range of professionals, the person, their families, previous care providers and by the use of independent advocates.

We saw that care plans were regularly monitored with formal reviews taking place. This included involvement of the individual at all stages appropriate to their abilities and capacity to understand. There was a great deal of individually focused work around

people's ability to understand and the home involved speech and language therapists to develop communication and understanding with people. We observed staff using ways of working with people as was set at in the individuals care plan and management strategies. We saw that staff were skilled at managing challenging behaviours and employed strategies that minimised risk and the need to use restraint and that minimised other restrictions on people. This allowed people whose behaviour may be termed as challenging, to access the community and enhanced their quality of life as a result.

A notable feature of this service was the person centred approach and the positive behaviour model used for supporting people whose behaviour could be termed as challenging. This had a positive impact on the experience for people using the service as people previously having lived in quite restrictive environments, such as hospitals, were now living in a community setting with active and interesting lives. They were being skilfully supported to take part in the local and wider community.

We found that people had received an annual health check and told us they had good access to local GPs, dentist and other community services. Staff were liaising with community healthcare professionals to ensure that health plans were up to date. We saw evidence that people's medication was being regularly reviewed and where this was to help manage behaviours that may challenge this had involved a consultant psychiatrist. The home had also developed health passports that provided up to date details if the person need to have a hospital stay or involvement with healthcare professionals who knew them less well.

Social workers we had contact with said they had been impressed with how the home had developed people's involvement with the local community. They reported that staff had helped people to develop new skills, and that risk assessments supported people to try out new activities.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The people we spoke with told us that they felt safe and were comfortable approaching staff with any concerns. One person told us, "Its all right here, I feel safe here." And another said, "I feel very safe, you can talk to staff."

Some people in the home occasionally needed physical restraint to keep themselves and others from harm. We saw that staff were skilled at managing challenging behaviours and employed strategies to minimise risk and the need to use restraint or place other restrictions on people. We were given the policies and procedures for the use of restraint within the service. The restraint training model, based around the principles of a non-physical intervention, was fully accredited and up to date. All staff were trained in this method to an advanced level, with regular updates.

Staff placed an emphasis on using restraint as the last resort and used positive management plans to reduce the need for restraint. We saw evidence of how the use of restraint was monitored, and this confirmed the low level of restraint used on people. Any increases to the figures were analysed and fed into lessons learnt from these incidents to reduce any future reoccurrences.

People's mental capacity had been assessed, to ensure they were not subject to inappropriate restrictions. Restraint was being monitored and used appropriately; ensuring it was kept to a minimum. This meant that people were in receipt of safe and effective care that met their needs.

Senior staff provided us with a copy of the local adult safeguarding policy and procedures used by the service. These were detailed and gave staff the necessary information to carry out the procedures correctly. We spoke in-depth with two members of staff who were both aware of the local area safeguarding policy and procedures. They were clear on the necessity to report to social services who would then lead any investigations. Staff also had a sound understanding of whistle blowing procedures. They were able to explain to us what they would do if they needed to use these procedures to raise concerns or to make a safeguarding referral. When interviewed staff were also clear about the signs and symptoms of abuse and they said they had regular training updates. We saw that

appropriate training and systems were in place so that staff acted and responded appropriately to protect people's rights and welfare.

When interviewed staff were aware of their responsibilities in relation to safeguarding. They were aware of the action to take if there was any suspicion of alleged abuse. Staff told us about the on call procedure which was in place should staff need support when managers were not at the service. We saw that appropriate referrals were being made for investigation to the local social work team. These were also reported to us, CQC as required by legislation.

The manager told us that systems were in place to both prevent and identify abuse. This included internal monitoring that the organisation undertook, by for example looking at all daily notes to ensure no safeguarding issues had been missed, and by data analysis of incidents.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

The provider demonstrated to us they had a quality assurance system in place. We saw the policy and procedure for this and a senior manager from the organisation carried out monthly visits to audit the quality of care, staff training and supervision and the home environment. When we visited the organisation's quality assurance manager was in the home carrying out a monthly audit of people's care plans. The results of these findings were examined and we saw that issues identified had been acted on. These records were examined and found to be robust and thorough in checking that the systems in place to ensure quality and safety had been adhered to and were being met.

There was evidence that learning from investigations and surveys took place and appropriate changes were implemented. This included asking people who used the service, their representatives and staff for their views. A formal survey was sent out and for those people who had family to represent them. These people were asked about the care their relative was receiving at each review meeting. We saw an example whereby activities had been changed as a result of comments from people in the home.

We saw that Low Fauld had an up to date risk assessment file where hazard risk assessments had been undertaken. These looked at all potential risks within the home environment and with each individual with control measures to reduce any risk. These were communicated to the staff through one to one supervisions, staff meetings, a staff message book and by staff signing each new risk assessment and policy to indicate they had read and understood them. The records to assess risks were examined and found to be well kept and orderly with the level of risk clearly identified by a colour coded system, for example red to identify high risk.

This system was further strengthened by staff having designated key areas of responsibility. For example one staff member told us about their role in recording, monitoring and analysing the use of restraint in the home. These key staff received training and regular updates and ensured that all staff were updated and briefed in these areas.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

The home had systems in place to record, and securely retain information regarding the care delivered to people. These included care plan and assessment records, daily reports and information from visiting professionals. These records, although held in a locked cupboard, were easily available for staff to read and update. Personnel, supervision and training records were also kept securely in locked cabinets in the administration office.

The home kept records of incidents and accidents. These were monitored to identify any trends and record actions taken. The home carried out a range of audits such as for infection control, medicines management and the use of restraint. We noted that the audit documentation was detailed and identified any action required. These audits were completed by the registered manager. We saw that the home was submitting the relevant notification into us, CQC, as required by law.

The home had accurate and up to date records related to the running of the home which assisted in maintaining a safe environment for people and staff to live and work in. This included environmental checks regarding the fire alarm system, water hygiene, health and safety and electrical appliance testing. We found equipment testing and maintenance records were up to date. The home kept comprehensive records of activity and environmental risk assessments. These were detailed and included measures to minimise the risks identified.

The manager and the organisation were following the requirements of the Data Protection Act 1998 and were aware of the timescales for retaining records.

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

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