Inspection Report

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

Grovelands Farmhouse

Tandridge Hill Lane, Godstone, RH9 8DD

Tel: 01883744128

Date of Inspection: 17 March 2014

Date of Publication: April 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Consent to care and treatment	✖ Action needed
Safety and suitability of premises	✓ Met this standard
Supporting workers	✖ Action needed

Details about this location

Registered Provider	Consensus Support Services Limited
Registered Manager	Mrs Dawn Head
Overview of the service	Groveland's Farmhouse provides care and accommodation for up to 7 adults with an Autistic Spectrum Condition. Groveland's Farmhouse is in a country location, accessible via a single-track road. There is no public transport nearby. There are parking places in the home's grounds
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

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 17 March 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 people who use the service, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We received concerns from a number of whistleblowers, mainly regarding people's rights, choices and freedom of movement being denied at this service. Although concerning it was also a positive sign that the provider had created an environment where people felt reasonably safe to whistle blow, and that system was working in practice.

We therefore conducted an unannounced inspection and early in the morning at 6:20am before the day shift to respond to the concerns that were raised by the whistleblowers. We started at this early time because that was one of the key times that the whistleblowers reported denial of choices and rights was occurring and we had previous concerns in this area as highlighted in the last report under outcome 2 consent (regulation 18).

As there were also previous compliance actions in related areas we also reviewed these at this inspection. We found some of the whistleblowers concerns were substantiated and are addressed under outcome 2 consent (regulation 18) where we already had concerns and a new area, outcome14 (regulation 23) staff supervision where we found that people were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. .

The last inspection found shortfalls in 2 out of 4 areas looked at and set compliance actions. The areas were shortfalls were found were, consent to care and treatment and the environment.

At this inspection we also reviewed the actions the provider had taken in response to the compliance actions.

The last inspection report recorded shortfalls under outcome 10 (regulation 15) with the environment and set a compliance action. At this inspection we reviewed the actions the provider had taken in response to the compliance action and we found that the provider had addressed the areas where we had identified shortfalls. This compliance action was therefore met and closed. We therefore found that people who used the service, staff and

visitors were protected against the risks of unsafe or unsuitable premises.

The last inspection report recorded shortfalls under outcome 2 (regulation 18), consent to care and treatment and set a compliance action. At this inspection we reviewed the actions the provider had taken in response to the compliance action and we found that the provider had not made significant progress. However as the management explained the reason was a lack of understanding of the procedures required and did make some improvements during the inspection, it was seen proportional not to escalate our actions and just leave the compliance action in place on this occasion. This compliance action therefore remained open and we found that before people received any care or treatment they were not always asked for their consent, the provider did not always act in accordance with their wishes and where people did not have the capacity to consent the provider did not always act in accordance with legal requirements.

A suitable manager was put in to the home during the inspection to cover until the new manager starts. We were reassured by the managers knowledge and positive attitudes in the areas we had found shortfalls. The availability of a manager to address the shortfalls in this report therefore reduced the level of impact we assessed those shortfalls would have on people.

It was seen as responsive, that the provider, once they clearly understood what was required, started to take immediate action during the inspection to make improvements. In addition one of the directors took the time to directly feed back to one of the people using the service about the positive changes and improvements they could now expect in their lives, regarding their rights, freedoms and choices and how now they would be more appropriately supported.

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

What we have told the provider to do

We have asked the provider to send us a report by 29 April 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The last inspection report recorded shortfalls under outcome 2 (regulation 18) with consent to restrictions.

At this inspection we reviewed the actions the provider had taken in response to the compliance action and we found that the provider had not taken sufficient action to become compliant.

The last inspection report recorded the following shortfalls and included it in the compliance action.

'The home had not assessed people's capacity to consent under the mental capacity act where they were making decisions for them. During discussions with staff we identified a number of examples of decisions that had been made for people who were thought not have the capacity to consent, made by staff. For example, medical screening and intervention, the use of baby monitors and although people get enough food they don't get what they want as there was restricted access to food.'

'We also found restrictive some practices like the locked front door on a keypad, risk assessments for secure window restrictors and for people not being allowed outside the home unescorted. Although the staff had done risk assessments and involved other professionals in making decisions to protect people, they had not assessed everyone affected capacity to consent or followed how to made decisions for the person when there was a lack of capacity, in line with the procedures required under the Mental Capacity act.'

At this inspection we found that the service had still not assessed people's capacity before making decisions on their behalf or imposing restrictions upon them. The director told us that they had not completed the assessments due to not being clear what was required. We clarified that the home was required to determine capacity in each separate area that the service wants to restrict them for their own protection before any restrictions are imposed upon them. We also clarified that the tool required for this was called a 2 stage mental capacity assessment and those would also be required for consent to care and treatment where capacity to consent was found lacking. This part of the compliance action was therefore unmet.

The last inspection report also recorded the following shortfall and included it in the compliance action.

'The keypad locked front door and main food storage cupboard were examples of a restriction that affected everyone but was based only on one or two persons' needs.'

At this inspection we saw that the director was still trying to find an appropriate replacement or the keypad by looking at fobs and so on, so that the restriction of the locked front door would not need to affect other people. We noted the director was testing a different card swipe lock system on the day. We also received concerns from staff that some people who use the service did not have the confidence to use electronic locks and were therefore being restricted by the lock and losing their independence. Although the director had taken action more was required to address the concern. We therefore found that this part of the compliance action also remained unmet.

We concluded that although there had been some work towards the previous compliance action the shortfalls previously identified still remained. The service was therefore still not compliant with outcome 2 (regulation 18) and the compliance action remained open.

We also received concerns from a number of whistleblowers, with similar concerns to those found in this area at the last inspection, mainly regarding people's rights, choices and freedom of movement being denied at this service and possible negative consequences.

Whistle blowers told us they were concerned that the rights of one of the people using the service were not being upheld because people were not allowed to make their own choices where people had capacity to make their own choices, were being treated like they didn't have capacity to make decisions when they did, were being mothered, over restricted and over controlled where there was no risk of significant harm.

We spoke to people who use the service who confirmed this was the case. One person we spoke to told us that 'they don't let me smoke when I want. I have to wait till 7 in the morning and can't have one after 9:45 at night. I don't like it, I'm an adult, I'm 23. I can't go out in the mornings I have to wait for day staff'

We found that in this case the restrictions were inappropriate and had been made due to not enough staff being provided to meet people's supervision needs while smoking or out. We found this an unsatisfactory reason as the service is required to provide sufficient staff to meet people's needs and was not doing so. The provider should note to remain compliant with outcome 4 (regulation 9) and possibly outcome 13 (regulation 22) staffing needs to be addressed so as everybody's needs are fully met.

We spoke to people who use the service about their freedoms and choices and one person said 'staff stop me doing things I want and they had set up loads of rules about what I can and can't do and I'm not happy with it. They also set up chores without talking to me about it and no one else has to do chores only me so it isn't fair and I don't like it. They did it in a meeting, I wasn't involved. They set it all up without asking me and I wasn't involved. Can you ask them if I could be allowed to my own cigarettes especially when out. They won't let me have diet coke. I can't have one till 12 (noon) and have to have my last one at 7pm. I'm not happy about that. It's a bit out of order choosing a time they want and making me follow it.'

We found that in this case the restrictions were inappropriate and had been made due to staff not understanding the difference between some rare rules required to protect people from significant harm where it would be appropriate and where they should only be offering encouragement information and support to assist the person if wanted to make their own informed decisions.

For example an appropriate restriction might be where one person was at risk from roads and traffic not being allowed out unsupervised after the appropriate legal assessments of capacity in order to protect them from significant harm. However, the staff were inappropriately making numerous decisions and rules for people when there was no risk and justification. This also meant that people were being treated as if they did not had capacity to make their own decisions in area they did and were therefore being denied that rights.

We found that staff were treating people as if they did not have capacity to make the decision, making illegally and un necessary rules and restrictions on people and was enforcing those decisions, as the person using the service above had described in their examples of their access to drink and cigarettes being controlled by staff.

A manager was brought in during the inspection to cover the home until the new manager starts. We discussed our concerns with the covering manager and were reassured by their clear understanding of this area and the rights people had. The covering manager demonstrated a clear understanding of the difference between the rare need to restrict someone for their own protection, and allowing people to make their own choices, even if they are bad choices as we all have the right to make. The covering manager was also clear that as and opposed to restrictions and rules, staff should be offering education, information and support to help the person make more informed decisions and being clear all the time that it's the persons own choice. For a hypothetical example staff would be encouraging and supporting with a weight loss diet that was agreed and if the person wanted to brake the diet it would be their choice like us and staff should not stop them doing what they choose or set up rules or restrictions to food. We therefore felt confident that practices would start to change and staff would receive clear guidance so that this area would be more effectively addressed managed than before the inspection.

It was seen as responsive, that the provider, once they clearly understood what was required, started to take immediate action during the inspection to make improvements. In addition one of the directors took the time to directly feed back to one of the people using the service about the positive changes and improvements they could now expect in their lives, regarding their rights, freedoms and choices and how now they would be more appropriately supported.

We concluded that people who use the service were being denied their rights to make their

own decisions, freedom of movement and human rights because the service did not have proper 2 stage mental capacity assessment procedures for determining capacity and obtaining consent to care and treatment where capacity was lacking in line with the Mental Capacity act. The service was also treating people with capacity to make decisions like they did not have the capacity to make their own decisions and was overriding that right, making petty, unreasonable and illegal rules and over controlling people's lives.

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.

The provider had taken steps to provide care in a home that was suitably designed and adequately maintained.

Reasons for our judgement

The last inspection report recorded shortfalls under outcome 10 (regulation 15) with the environment and set a compliance action.

The last inspection report recorded the following shortfall and included it in the compliance action.

'We noted that although risk assessments had previously been completed for people that needed secure window restrictors to be fitted for their own safety, we saw that the window restrictors on upper floors, in their rooms, were not of a secure type being a chain similar to a plug chain screwed into the plastic with a screw each end, and others were not present.'

At this inspection we saw that new robust and made for the purpose window restrictors had been fitted to windows. These also had a lock so that where risk assessed as safe for an individual the window restrictor could be unlocked so as not to restrict the window when not needed. This part of the compliance action was therefore met.

The last inspection report also recorded the following shortfall and included it in the compliance action.

'the sharps draw that is used to lock away knives and other sharp objects risk assessed as dangerous to the people living at the home was not being well managed. There were 15 items in the locked draw with only 5 being sharp the rest were for example bendy plastic serving spoons and wooden stirring spoons. In addition we found a meat temperature probe with a sharp steel probe for piercing into the meat to test the temperature, but this was inside in an unlocked draw.

At this inspection we saw the sharps draw was locked and it was also locked at the day of the following feedback meeting. When we checked its contents only appropriate sharps were stored in the draw. This part of the compliance action was therefore met.

The last inspection report also recorded the following shortfall and included it in the

compliance action.

' The fire door to the dining room/ lounge was split at the top and when we tested it with staff it would not close properly reducing its fire retention period and removing the smoke protection offered by the smoke seal strips.'

We therefore found all parts of the previous compliance action met and the compliance action was closed.

During this inspection we noted that the windowsills to the office were rotten and had melted away almost completely in some cases. We tested the windows and frames which were still secure. As they were secure a note only will be made here to remind the provider that this will need to be addressed before it becomes unsafe for the provider to remain compliant in this area.

We also saw at this inspection that the first floor bathrooms floor coverings were starting to split as was the wooden shirting to the shower. These areas would then present an infection control issue as it is not possible to clean where liquids had entered unsealed cracks in flooring and wood. We saw this had been identified by the director and was on their works programme. The provider should note that to remain compliant in this outcome area they will need to continue their plans to repair the flooring and wood in the bathrooms in a timely fashion.

We concluded that the areas of previous concern had been addressed by the service and new areas were identified and in hand. The service was therefore now compliant with outcome 10 (regulation 15).

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff did not always receive appropriate professional development and support.

We received concerns from whistleblowers regarding a lack of staff supervision.

We checked supervision records for the home with the Director. We found that in the last 6 months most of the staff had only received one supervision session and some had received no supervision.

The director agreed that this was an insufficient level of staff supervision.

We also noted that there had been a lack of a manager. A suitable manager was put in to the home during the inspection who will cover until the new manager starts. We were reassured by the managers knowledge and positive attitudes in the areas we had found shortfalls. The availability of a manager to address this lack of supervision and the other shortfalls in this report therefore reduced the level of impact we assessed the shortfalls would have on people.

We concluded that the home had not provided regular formal recorded supervision for all of its staff, which meant the home could not support all staff with, or effectively address, their performance, conduct, training and development needs.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Before people received any care or treatment they were not always asked for their consent and the provider did not always act in accordance with their wishes. Where people did not have the capacity to consent the provider did not always act in accordance with legal requirements because they had not taken appropriate steps and where people lacked capacity in establishing capacity, and acting in accordance with the best interests of the person in line with the Mental Capacity Act 2005. Regulation 18.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The service had not provided regular formal recorded supervision for all its staff, which meant the home could not support all staff with, or effectively address, their performance, conduct, training and development needs. 23(1) (a).

This section is primarily information for the provider

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 by 29 April 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.