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: 20 August 2013

Date of Publication: October 2013

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

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

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

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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'.

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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 20 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 staff and reviewed information given to us by the provider.

What people told us and what we found

People told us they had enjoyed their meal, liked the food and got enough to eat. They said they had choices of food and they could have a snack or a drink at any time.

We saw that people decided what to eat on the day as opposed to deciding weekly menus. This offered more flexibility and choices.

People said they liked their rooms and they were warm enough in winter.

One of the people who used the service who had an interest in health and safety took us on a building tour and told us how they were supported to do a monthly check for the building.

We found that the provider had not assessed capacity to consent for all of the people who lived at the home and had not taken appropriate steps where people lacked capacity in line with the Mental Capacity act.

We found that the home was not always protecting people against the risks associated with unsafe or unsuitable premises, as they were leaving windows without secure restrictors fitted when these had been risk assessed as needed, not managing sharp objects as risk assessed, and not attending to fire doors with known faults.

We also found that files containing information about staff and those of people who use the service were in good order and kept securely and confidentially.

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 02 November 2013, 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.

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 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

Groveland's Farmhouse is a care home that specialises in providing care and accommodation for up to 7 adults with an Autistic Spectrum Condition between the ages of 18 and 65 years, some of who may have other conditions, for example dementia.

We saw that consent to medication was sought at the time of administration and people's body language or communication methods were used to determine refusal. We also saw that no covert medication was being administered.

We saw that the service had restraints procedures and training was available and staff had attended it, but the manager had risk assessed that the restraints policies did not need to be used at this home based on the needs of the particular group of people currently living there.

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 by staff for people who were thought not have the capacity to consent. For example, medical screening and intervention, the use of baby monitors and although people get enough to eat, there was restricted access to food.

We also found some restrictive practices such as the locked front door on a keypad, risk assessments for secure window restrictors and 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 people's capacity to consent or

followed procedures for making decisions for the person as required under the Mental Capacity Act.

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 people's needs.

The management of Grovelands Farmhouse agreed to look for more creative solutions to these issues that would minimise the impact and maximise independence for people. For example, a swipe fob key for the front door for those who do not need that restriction for their protection.

We found that the provider had not assessed capacity to consent for the people who live at the home where required and had not taken appropriate steps where people lacked capacity in accordance with the Mental Capacity act.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

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

Groveland's Farmhouse specialises in providing care and accommodation for up to 7 adults with an Autistic Spectrum Condition, some of which may have other conditions, for example dementia.

The company also owns a working farm next door to the home. A range of daytime services for people at the home and others occur at the farm, for example working with animals, arts and crafts and learning about horticulture.
Groveland's Farmhouse is in a country location, accessible via a single-track road.

One of the people who used the service who had an interest in health and safety took us on a building tour and told us how they were trained and supported to do a monthly check for the building.

There are seven bedrooms in the main farmhouse, with a separate bungalow offering two self contained flats, designed to support two people suited to a more independent lifestyle.

People said they liked their rooms and they were warm enough in winter.

We saw, where we had their permission, that people's bedrooms were homely, individualised to their tastes and reflected their personality and interests. Some people who used the service like a lot of privacy with regards to their bedrooms and we saw staff and other people who use the service recognise and respect this.

We noted that although risk assessments had previously been completed for people that needed secure window restrictors to be fitted for their own safety, the window restrictors in some upper floor bedrooms were not of a secure type, being a chain similar to a plug chain screwed into the plastic with a screw each end, and in others there were none present.

The management agreed to risk assess the need for restrictors on an individual basis and

restrict securely where needed and not where not needed.

We saw that there was sufficient communal space for people, with a lounge and adjoining dining room that could seat everyone if needed and an additional breakfast room. The garden was pleasant and well maintained.

The home uses baby monitors to monitor people at night.

We found 3 baby monitors switched on in the communal lounge for people who were still asleep so that we could hear their private noises.

These were on at a time when other people using the service were also using the lounge. When we asked staff what time they turned them off, they said when the people got up. We asked what happened if people stayed in bed late or all day and were told the monitor would be left on during the day in that case.

The home's management agreed that during the day this was not a suitable area for staff to use to monitor individuals while they sleep, and that they would use the main office in future.

The kitchen was suitable in size for people to use with and without support as required and we saw that people did so.

However the sharps drawer, which was used to lock away knives and other sharp objects that had been risk assessed as dangerous to the people living at the home, was not being well managed.

There were 15 items in the locked drawer 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 end for piercing into meat in an unlocked drawer.

Our inspection was unannounced and started at 7:55 am before the manager arrived.

We found that the home was hygienic, clean and fresh.

Toilets and bathrooms were clean, as was the rest of the building. Toilets were functioning, regularly cleaned and had supplies of paper towels and liquid soap.

We saw the Control Of Substances Hazardous to Health cupboard was locked so that COSHH products were not accessible to people.

There was a fire alarm system, which was regularly checked. Fire doors had automatic closing devices and smoke seals, and there were internal emergency lighting systems.

However, 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. This reduced its fire retention period and removed the smoke protection offered by the smoke seal strips.

There was a maintenance record book that recorded when maintenance issues had been identified and when the work was completed, to evidence a timely and risk assessed response to any maintenance issues arising.

The maintenance record book, however, did not show a timely response to identifying this maintenance requirement or reflect a risk assessed response. The record showed that the damaged fire door was identified on the 3rd of July 2013, which was over six weeks before the date of this inspection where it was still not repaired and people left at potential increased risk.

We found that the home was not always protecting people against the risks associated with unsafe or unsuitable premises, as they were leaving windows without secure restrictors fitted when these had been risk assessed as needed, not managing sharp objects as risk assessed, and not attending to fire doors with known faults.

We found that although the building was in reasonable decorative condition, hygienic and clean, the provider had not always taken steps to provide care in a home that was suitably designed and adequately maintained.

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 against the risks of unsafe or inappropriate care and treatment because records could be located promptly when needed, were kept confidentially and securely, for appropriate period of time and then destroyed securely.

Reasons for our judgement

We found people's records to be well organised, in good order and suitable for purpose.

We found documents to be well laid out and clearly written so we could navigate documents and records and find information readily and effectively.

Staff records were kept confidentially and securely.

We saw that staff records were stored in one location securely in the main office and in a locked metal filling cabinet that only the manager has a key for.

People's records were kept confidentially and securely.

Medication and associated records were stored securely in a locked metal cupboard fixed to the wall.

We saw that all the people's records were stored confidentially and securely in one location in the main office. We did not find people's files left around the home in communal or public areas.

Records could be located promptly when needed.

During our inspection we found that staff could locate and produce documentation and records promptly when asked and that records were well organised.

Records were kept for appropriate period of time and then destroyed securely.

We saw that files were first archived in a lockable room in the garage on site. When no longer needed the home now has retention period guidance and policies to ensure required information is destroyed appropriately, and has started to implement this.

The provider should take note that the home needs to continue to implement the recently acquired retention period and secure destruction guidance to maintain future compliance

with this standard.

The home had clear policies that were reviewed, and the documentation pertaining to the people who use the service was held securely, confidentially and properly managed.

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: 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 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 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People were not always protected against the risks associated with unsafe or unsuitable premises, as the provider was leaving windows without secure restrictors fitted when these had been risk assessed as needed, not managing sharp objects as risk assessed, and not attending to fire doors with known faults. Regulation15.—(1) (a) (b) (c)(i).

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 02 November 2013.

This section is primarily information for the provider

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

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