The Fremantle Trust

Farnham Common House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service:
Farnham Common House is a purpose-built residential care home. It was providing personal care to 44 older people and people with dementia at the time of the inspection.

People's experience of using this service:
• People were cared for by kind and caring staff who understood the support they required.
• People's diverse needs were met.
• People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
• The environment was designed to meet the needs of people with a range of disabilities. It had appropriate equipment in place to support daily living.
• Checks and servicing took place to ensure the premises were safe.
• People received appropriate support with their medicines and any healthcare support they required.
• There was effective monitoring of the service to ensure people's needs were met.
• Staff received the training and support they needed to meet care needs and to develop as professional workers.
• The provider had clear visions and values about how it expected the service to be run. The staff team achieved these.
• There were some areas where care could be improved. We have made recommendations about recording people's healthcare needs and about palliative and end of life care needs, to ensure these are documented and provide guidance for staff.

Rating at last inspection:
The service was rated 'Good' at the last inspection on 13 and 14 June 2016. We published our report on 27 June 2016.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Inspections will be carried out to enable us to have an overview of the service. We will use information we receive to inform future inspections.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Farnham Common House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
On the first day, the inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care of older people and dementia care. The second day of the inspection was carried out by one inspector.

Service and service type:
Farnham Common House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a registered manager. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity started on 13 February 2019 and ended on 18 February 2019.

What we did:
• We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We reviewed notifications and any other information we had received since the last inspection. A

notification is information about important events which the service is required to send us by law.
• We contacted social care professionals, to seek their views about people's care.
• We spoke with the registered manager and 12 staff members in a range of roles.
• We spoke with ten people who live at the home and one relative.
• We checked some of the required records. These included six people's care plans, medicines records in three of the home's four groups, four staff recruitment files and staff training and development files. Other records included those which related to safety of the premises, accident forms, auditing reports and complaints.
• We observed part of an activity session.
• We observed mealtimes in different parts of the home.
• We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:

• People told us they felt safe at the service. Comments included "I feel quite safe," "I feel much safer here" and "I feel quite safe, there are plenty of people around you."
• Staff undertook training in safeguarding people from abuse as part of their induction training. Information was displayed in the home about reporting concerns to the provider and external agencies.
• The registered manager reported any safeguarding concerns to the local authority and carried out investigations as required. They also notified us of any referrals they made to the local authority.
• Managers took appropriate action where staff had not carried out care to the expected standards.

Assessing risk, safety monitoring and management:

• Risk assessments had been written to identify and reduce any risks to people's safety and welfare. These included areas of practice such as moving and handling, the likelihood of developing pressure damage and the risk of malnutrition.
• Accidents were recorded and showed appropriate actions had been taken, such as calling emergency services. A member of staff described in detail the actions they would take if someone fell.
• Equipment was provided to help people reposition, such as hoists. Equipment was serviced to ensure it was in safe working order.
• The premises were maintained well. Gas, electricity and water supplies were checked to ensure they conformed to acceptable safety standards. Faults were reported to the landlords, for attention.
• Staff responded calmly and patiently when people showed distressed behaviours. This was done in a respectful way.
• The home was inspected by a fire safety officer from Buckinghamshire Fire and Rescue in February 2018. Their report included "A reasonable standard of fire safety was evident."
• We saw from records routine checks were made of exit routes, fire call points and emergency lighting, as examples. A fire risk assessment was in place for the premises, dated January this year.
• Fire safety training took place. Most staff had taken part in practice evacuation of the premises. The registered manager was able to give us assurance further practices would take place for those staff who had not yet been involved in simulated evacuations. Dates for training were sent to us a couple of days after our visit.
• Personal emergency evacuation plans had been written for each person, to outline the support they would need to leave the premises in the event of a fire or other emergency.
• The fire alarm system and extinguishers were regularly serviced by a reputable contractor.

Staffing and recruitment:

• Staff were recruited using robust procedures. This included a check for any criminal convictions, written references and proof of identification. Records showed staff only started working after all checks and clearances had been received back.
• Staffing rotas were maintained to ensure appropriate cover was provided in all areas of the home. Managers responded promptly to cover any gaps to the rotas when there were unplanned absences, such as sickness.
• Staff were deployed appropriately around the building to ensure people's needs were met. A senior member of staff was on duty at all times to lead and co-ordinate the shift. Many of the staff we spoke with had worked for the provider or at the home for a number of years and were confident in their roles. There was constant staff presence in lounges where this was required, following incidents with or between people.
• Staff received training in safe practices. This included moving and handling and first aid.

Using medicines safely:

• People received their medicines in a safe manner. Individual medicines folders contained a photograph of the person and any allergies were noted in red ink so they were clear and visible.
• Medicines were stored safely in locked medicines trolleys. They were stored in an air conditioned room to ensure they remained below a safe temperature of 25° Celsius. Appropriate storage was in place for medicines which had the potential for abuse (controlled drugs).
• Staff who administered medicines wore red tabards to show they were busy and to prevent being disturbed. Staff ensured people had a drink to take their medicines and supported them gently. One member of staff told a person to "Take your time, no rush" and said "Thank you" after they had taken their tablets.
• Appropriate records were maintained after medicines had been given to people. We mentioned to the registered manager where staff had not fully completed an additional chart for one person, to show they rotated application of skin patches around the body. Rotation is necessary to reduce the likelihood of the skin becoming sore or inflamed, due to repeated application in the same place.
• There was appropriate guidance for staff on the safe use of medicines. Training was undertaken by staff who were involved in administration.
• Medicines records were checked as part of the staff handover, to ensure records were up to date and to query any gaps, if necessary, before staff went off shift.

Preventing and controlling infection:

• The premises were kept clean and hygienic. Staff undertook training in infection control practice to prevent the spread of infection.
• Staff had access to and wore disposable items such as gloves and aprons for when they assisted people with personal care or when they served food.
• Clean and dirty clothes and linen were kept separate in the laundry. Soiled washing was placed in red, dissolvable laundry bags, which could then be placed directly in washing machines. This prevented further direct handling and reduced the risk of infection.
• Toilets were well stocked with hand wash and paper towels to enable effective hand hygiene. Alcohol-based hand gel was available around the building to sanitise hands.
• There were appropriate arrangements in place with an approved contractor for the disposal of clinical waste. This ensured the wider environment was protected from hazardous waste.
• The service had been awarded the highest possible rating by the Food Standards Agency in March 2018, for its food safety practices.

Learning lessons when things go wrong:

• Records of accidents, including falls, were analysed to look for any trends and prevent recurrence. A relative commented their family member "Has had a few falls but they take lots of preventative measures." They said their relative was "Quite unsteady but can't fault the staff." Where necessary, people were referred to relevant healthcare professionals for advice.
• Staff were clear about reporting any concerns they had. This included changes to people's well-being and the actions they would take if they noticed, for example, someone's skin was becoming sore.
• The provider cascaded information about national safety alerts to all of its services, so action could be taken, if required. We saw leaflets about the combustion hazards of paraffin-based emollient creams where people smoked and the actions to take.
• The provider and registered manager complied with any recommendations made by the local authority following enquiries or investigations.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

• People's needs were assessed before they came to the service. We read an example of one person who had recently been assessed. This was comprehensive. The senior member of staff who carried out the assessment told us they had suggested to the person's relative they bring in some items for the bedroom before the admission day. This was to provide familiar belongings to help the person settle in.
• Effective care and support was enhanced through the use of technology, such as sensor mats in people's rooms. This alerted staff if people at high risk of falls were moving around, especially at night.

Staff support: induction, training, skills and experience:

• Staff undertook a four day corporate induction before they started at the home. This included completion of training the provider considered mandatory. They then worked supernumerary at the home and shadowed experienced staff.
• Staff were enrolled onto the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work.
• New staff were subject to two probationary reviews, to assess their performance before they were confirmed in post. Probationary periods were extended, where necessary.
• There were systems for supervising and appraising staff to ensure people were cared for by workers with the necessary skills and knowledge to support them.
• There was on-going training for staff, to update and refresh skills. Staff were encouraged to undertake more in-depth training, such as Business and Technology Education Council (BTEC) awards in dementia and management. Further courses had been arranged where staff needed refresher training.

Supporting people to eat and drink enough to maintain a balanced diet:

• People were complimentary of the food at the home. Comments included "Plenty to eat and drink," "Lovely. (You can have) as much as you want. It's very nice," "Food is good" and "Have eaten here quite a lot. (They) do really well at Christmas and birthdays, very welcoming. Food is well prepared."
• There were choices at mealtimes. Menus were provided on tables. The chef could prepare alternatives if people did not like the day's choices.
• Food was presented well and looked appetising. Special requirements were catered for, such as pureed meals.
• We observed mealtimes were relaxed occasions. Tables were nicely laid with a cloth and colour co-ordinated place mats. Napkins were provided. People were able to take their time and enjoy their food

unrushed.
• People were offered more to eat and drink when they had finished what was initially provided.
• People were assessed for the likelihood of becoming malnourished.
• People were referred to speech and language therapy (for swallowing assessments) or the dietitian, where required.
• The chef fortified meals with cream, butter and milk powder, to increase calorific content. The home took a "food first" approach where people were at risk of weight loss. This was in line with national good practice in the prevention of malnutrition.

Staff working with other agencies to provide consistent, effective, timely care:

• Staff worked well together and with external agencies. This included the local authority, district nurses, the GP surgery and hospital services.
• Handover meetings took place between shifts, to share information about people's well-being and to communicate any tasks that required follow up.

Adapting service, design, decoration to meet people's needs:

• The building was designed to meet the needs of people with a range of disabilities. Equipment was provided to assist people with daily living tasks. This included grab rails, adapted baths, showers and a passenger lift. There was level access around the building. Improved signage had been provided to show where toilets were located.
• Communal areas were comfortable and warm. There was an activity lounge where people from around the home could gather together.
• A pleasant quiet area had been created in one part of the home. We saw a person sitting there, enjoying watching people go past.

Supporting people to live healthier lives, access healthcare services and support:

• People's care plans recorded the support they needed to keep healthy and well.
• People were referred to healthcare professionals when needed. A doctor's round took place in the home each week. Additional GP visits took place as well. Records were kept of the outcome of these visits.
• People told us they had access to healthcare professionals. Comments included "Staff will call for a doctor if needed and contact the family. (I've not needed this) myself but have seen them deal with other people" and "They will call a doctor if needed." A relative told us their family member "Has a regular call from the doctors and other health professionals, as a matter of course."
• We heard staff explaining to people what their medicines were for and asking them if they were in any pain.

Ensuring consent to care and treatment in line with law and guidance:

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People were supported to have maximum choice and control of their lives and were supported in the least restrictive way possible.
• People's comments included "There are no restrictions. I can go out but don't choose to. Most of us go to bed early," "(There are) no real restrictions, we can make our own decisions" and "None whatsoever" when we asked if there were any restrictions.
• Applications to deprive people of their liberty were made to the local authority when needed.
• Best interest decisions were made on people's behalf where they lacked capacity.
• The service had obtained copies of Lasting Power of Attorney documents, where applicable. This ensured the service had satisfied itself it consulted the right people who had legal authority to make decisions on people's behalf.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:

• People consistently provided positive feedback about the care they received from staff and the service overall.
• Comments included "(Staff are) all pretty good, especially the lady through there…she is wonderful, marvellous, always willing to help," "They are very kind and caring with me" and "Very kind and helpful, willing to help with anything you need." Other comments included "The staff are very good, friendly and helpful" and "Polite and pleasant, can't ask for more." A relative replied "Very much so" when we asked whether people were treated with kindness and compassion.
• Staff spoke about people in a respectful and kind manner. This included when they described behaviours which had a negative connotation. They demonstrated they knew people's needs well and were able to tell us about these when we asked. Staff knew about people's backgrounds and their family situations.
• Staff showed concern when people appeared distressed or unwell. They spoke with people kindly and calmly and offered reassurance.

Supporting people to express their views and be involved in making decisions about their care:

• Staff supported people to make decisions about their care and knew when to involve relatives or other persons.
• Meetings were held at the home to ask people for their views about the service and to update them on developments. This included consultation meetings, which relatives were also invited to attend.
• Information was displayed about advocacy services. Staff would also advise people how to contact advocacy services, if required.

Respecting and promoting people's privacy, dignity and independence:

• People's privacy, dignity and independence were upheld by staff.
• People's comments included "They are respectful and understand my likes and dislikes. They do knock before coming into my room," "(They) will knock before coming in. If helping me up, they close doors and curtains and keep me covered" and "They always speak to us respectfully."
• We saw personal care was always carried out with bathroom or bedroom doors closed. Visiting healthcare professionals provided treatment to people in their bedrooms.
• We asked people if there were any concerns about personal care being provided by staff of a different gender. People either did not have experience of this or did not have concerns.
• Staff worked well with relatives to provide care in an integrated way. For example, where families liked to

assist their relative at mealtimes.
• Relatives and visitors were greeted by staff and engaged in conversation easily.
• People had been supported to look well groomed and good care was taken of their clothes and belongings.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• Care plans were in place for each person. These identified people's needs in relation to a range of areas including protected characteristics under the Equality Act (2010), such as age, disability, ethnicity and gender.
• Important information about some people's requirements was not prominent within their care plans. For example, we learned a person had diabetes only by reading a section about nail care and that they had swallowing issues by reading a medicines support plan. Separate care plans had not been written to outline what support they required in these areas. However, we spoke with care workers who were able to tell us about people's care requirements in detail and the actions they took to provide responsive care. In another part of the home, care plans were in place to ensure these type of support requirements were appropriately recorded. We discussed our findings with the registered manager, for their attention.
• We recommend the service consistently follows good practice in the recording of people's needs in relation to diabetes, swallowing difficulties and any other important health conditions.
• Staff were able to tell us how people liked to be cared for and their preferences.
• The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had assessed people's communication needs as part of their initial and on-going care needs assessments. This included any aids people needed to communicate effectively. For example, whether people wore glasses or required hearing aids.
• We saw examples of how some information was provided in accessible ways. For example, pictorial and easy read activity programmes, large print menus and use of photographs to record events at the home. This showed the service was working towards the principles of the AIS.
• Activities were provided for people. There had been an increase in activity co-ordinator hours since our last inspection. Activity programmes were displayed in the building.
• People told us "There are group activities. I like reading, crocheting, colouring in, knitting," "There are activities but I don't like to get into them, I like to watch TV," "They do take people out but I choose not to go," "Entertainment is good" and "There's plenty to do if you want."
• We observed part of a group gentle exercise activity. People had different levels of ability but all were encouraged to take part. We saw people smiled and laughed as they participated. We spoke with one person afterwards and asked if they had enjoyed the activity. They told us "Yes, it's good to do something different now and then."

End of life care and support:

• The service supported people with palliative care and end of life care. Managers involved healthcare

professionals where necessary.
• When we spoke with staff, we found differences of opinion about people's needs in this area. Some staff, when asked, identified particular people as being at end of life, others said they required palliative care. This highlighted a potential training and development need. The registered manager told us there was a course which staff would be attending later in the year.
• For people identified as receiving palliative care, there was no separate care plan to outline how their needs would be met. For example, pain control and recognition of pain and who was involved in their care.
• We recommend the service follows good practice in the recording of palliative and end of life care needs.

Improving care quality in response to complaints or concerns:

• There were appropriate systems for raising concerns about care at the service. Information was displayed in the entrance area and there was an additional suggestions box.
• Complaints were recorded and responded to. People could be confident their concerns would be looked in to.
• People knew how to make a complaint, if need be. Comments included "I would talk to the manager. He does what he can, even goes shopping for me," "I would speak to (name of registered manager). He is very approachable" and "I know the manager by sight."
• We asked people if they had any concerns. Their comments included "None whatsoever," "Not had a concern so far," "I don't think so" and "Just a few challenges with the landlord, which is not a reflection on the management or organisation."

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The service was consistently managed and well-led. Leaders and the culture they create promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

• There were inconsistencies in the completion of care records. For example, we saw examples where two people were assessed as being at high risk of developing pressure damage. There were no written plans in place to ensure staff carried out the necessary actions to prevent skin breakdown. However, staff were able to tell us what they did. For example, they turned people regularly, applied barrier creams and made sure people had appropriate mattresses on their beds. Staff confirmed there was no pressure damage, when we asked.
• Enhanced monitoring charts were in place where required. However, these were not always completed to show people were observed and supported around the clock. For example, one person's records showed they had not been checked after 9 pm on one day until 7:30 am the next day.
• The same person's fluid intake was monitored. Their charts showed they were offered a drink up to 9 pm on one day but not again until 8:30 am the following day.
• We could not be certain the person had not received appropriate care and support by night staff or if they had simply forgotten to complete the records. We brought this to the attention of the registered manager and they assured us they would follow this up.
• The service had a registered manager in post. They were experienced in the care of older people and people with dementia.
• People, including staff, spoke highly of the registered manager. They described them as "Approachable," "Very good" and said they were always visible within the home.
• The registered manager was supported by the provider and board of trustees to meet people's needs in a safe and effective way.
• Regulatory requirements were understood by the registered manager. For example, they notified us of certain incidents which had occurred during, or as a result of, the provision of care and support to people. We were able to see from these notifications that appropriate actions had been taken.
• Sensitive information was stored and handled in line with data security standards.
• Staff were clear about their roles, responsibilities and lines of accountability.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• Staff described a positive working culture where they all had learning and development opportunities.
• The provider's key values were displayed at the home and were understood by staff. These included 'to

celebrate the uniqueness in everyone', 'to put care and kindness at the heart of all we do' and 'to act openly and responsibly'. We found these values to be upheld at the home.
• Staff worked together as a team and shared information to promote people's well-being. They received appropriate training and support to carry out their roles.
• The registered manager understood their responsibilities towards the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

• People told us they felt listened to and involved in their care and the running of the home.
• Comments included "They find time to discuss things with you," "They often ask what we would like to do," and "Whatever you ask for, they try to respond."
• Staff meetings and residents' meetings took place at the service.
• The registered manager, deputy and assistant managers were accessible. Staff, visitors and relatives were able to speak with them to answer any queries.
• Copies of the provider news magazine were available for people to see what was going on in the organisation.
• The home took part and won two provider competitions in 2018, which were open to all of its services. These were for best garden in bloom and a bake-off challenge.
• Links had been established with a local school and children visited the service.
• Two young adults had completed Duke of Edinburgh awards through attending the service.
• Staff knew how to raise any concerns they had about people's welfare. They were advised of how to raise whistleblowing concerns during their training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace.

Continuous learning and improving care:

• Comprehensive quality assurance systems were in place. We read the four most recent provider audit reports about the service. These were detailed and contained areas where improvement could be made. The registered manager had or was in the process of taking action to attend to these.
• The provider invested in training to develop the staff team and improve the quality of people's care.
• The registered manager attended meetings held by the provider to share practice and learning within the organisation. They also attended a local care homes' forum.
• The registered manager kept their learning up to date.

Working in partnership with others:

• The service worked in partnership with other organisations to ensure people received effective and continuous care. For example, the local authority.
• "This is Me" documents had been completed to help support people in unfamiliar environments, for example if they needed to be admitted to hospital. These provided information about how people liked to be supported, to help ensure they received continuity of care.