The Shaw Foundation Limited

Homefield House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 8 and 9 May 2017.

Homefield House Nursing Home (to be referred to as Homefield House throughout this report) is a nursing home which provides nursing and residential care for up to 24 people who have a range of needs, including those living with epilepsy and diabetes and those receiving end of life care. The home provides specialist support to those living with dementia.

The nursing home comprises a large ground floor building set in secure grounds on the outskirts of Basingstoke town centre. The home comprises four distinct areas which are off the central corridor to the home known as 'The Street'. The Street is a large, naturally lit area which runs the length of the home and has reading material, interactive items upon the wall, a fake bus stop to act as a focal and reminiscence point, sensory objects and chairs and tables for residents and visiting friends and family. The four distinct areas to the home each contain six bedrooms, a bathroom and toilet, as well as a shower room with toilet. There is also a small kitchenette area, a dining and living room. At the time of the inspection 19 people were using the service.

At our last inspection on 23, 25 and 26 February 2016 we made a recommendation that the provider ensured appropriate equipment was available to support people to manage infection control. We also made a further recommendation that the manager sought further guidance on the environmental factors in the home to ensure they could be adapted to meet the needs of those living with dementia.

At this inspection we saw action had been taken to ensure these recommendations had been completed. Additional work was also planned to ensure the home's environment was developed further in order to continue to meet people's needs.

Homefield House had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. However it had not always been clearly documented that where people lacked the capacity to make specific decisions for themselves that actions taken on their behalf were always in their best interests. Staff sought people's consent before delivering their care and support.

People using the service told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people. People's safety was promoted because risks that may cause them harm had been identified and guidance provided to staff to help manage these

appropriately.

People were supported by sufficient numbers of staff to meet their needs. The provider was able to adapt their staffing levels appropriately when required in order to meet changes in people's needs.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely, staff had received the appropriate training to enable them to complete their role safely and medicines were stored, administered, disposed of and documented appropriately.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire, flood or utilities loss. These were easily accessible to staff and emergency personnel such as the fire service, if required to ensure people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable.

People were supported to eat and drink safely whilst maintaining their dignity and independence. We saw that people were able to choose their meals and were offered alternative meal choices where required. People's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

People's health needs were met as the staff and manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which apply to care homes. The manager showed an understanding of what constituted a deprivation of a person's liberty and was able to discuss the processes required in order to ensure people were not deprived of their liberty without legal authority.

People told us that care was delivered by kind and caring staff who sought to meet their needs and ensure they were happy. We saw that people had friendly and relaxed relationships with staff who would stop and speak with them when they had the opportunity to do so.

Care plans and risk assessments contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements and promoted their dignity. People were encouraged and supported by staff to make choices about their care including how they spent their day in the home.

People received care which was regularly reviewed to ensure contained the most up to date guidance for staff on how to effectively meet people's needs. Care plans and risk assessments were reviewed monthly to ensure they remained accurate to enable staff to meet people's needs.

People living with specific health conditions such as epilepsy for example were supported to manage these conditions safely. Guidance regarding the management and monitoring of people's blood glucose levels was sought and we saw this guidance was followed in practice.

People knew how to complain and told us they would do so if required. Procedures were in place for the manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff

were encouraged to provide feedback on the quality of the service during regular meetings with staff and the manager.

The provider's values and philosophy of care were communicated to people and staff. Staff understood these and relatives told us these standards were evidenced in the way that care was delivered.

The registered manager and staff promoted a culture which focused on providing care in the way that staff would wish to receive care themselves. The registered manager provided strong positive leadership and fulfilled the requirements which would be associated with their role as a registered manager.

The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe. Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff who were encouraged to raise concerns with the manager.

The quality of the service provided was reviewed regularly by means of effective quality control audits. These were completed to identify areas where the quality of the service provided could be improved. We could see action had been taken to address where any shortfalls in the service provision had been identified

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.

People were safeguarded from the risk of abuse. Staff were trained in safeguarding, understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified and detailed. Recorded guidance was provided for staff and reviewed monthly to ensure people's needs were managed safely

People were supported by sufficient numbers of staff to meet their needs in a timely fashion. There was a robust recruitment process in place to ensure staff had undergone thorough and relevant pre-employment checks prior to commencing their role.

Medicines were administered safely by senior staff who received training appropriate to their role to ensure medicines were stored, administered, documented and disposed of safely

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager had not ensured that where care was provided in a person's best interests that this had been documented appropriately involving all relevant parties in those discussions.

People were supported by staff who completed a nationally recognised induction process to ensure they had the skills and knowledge required to meet people's needs in an effective way.

People were supported by staff who were not always able to discuss the principles of the MCA however demonstrated a detailed awareness of how to enable and support people to make choices in their daily lives.

People were encouraged to participate fully in mealtimes to ensure they ate and drank sufficiently to maintain their health and wellbeing.

People were supported to seek healthcare professional advice were required in order to monitor, manage and treat their changing health needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach with people, supporting them in a kind and sensitive manner.

Staff had a well-developed understanding of people and had developed companionable and friendly relationships with them.

Where possible people were encouraged to assist in creating their own personal care plans to ensure their individual needs and preferences were known and provided by staff.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis with additional reviews held when people's needs changed.

People were encouraged to make choices about their care which included their participation in home activities and how they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner in accordance with the provider's complaint policy.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which placed the emphasis on people receiving quality care from staff who treated people in the way they would wish to be treated.

The registered manager provided strong leadership and fulfilled the requirements of their registration by informing the Care

Quality Commission about important and significant events.

Staff were aware of their role and felt supported by the registered manager. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The provider and registered manager regularly monitored the quality of the service provided so that continual improvements could be made.

Homefield House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 8 and 9 May 2017 and was unannounced. The inspection was conducted 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 use this type of care service, on this occasion they had experience of family who had received care. The Expert by Experience spoke with people using the service, their relatives and staff.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also reviewed the Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people, three relatives, one nurse, five members of care staff, the chef, the activities co-ordinator, two visitors and the registered manager. We looked at five care plans, five staff recruitment files, staff training records and 10 medication administration records. We also looked at staff rotas for the four weeks prior to our inspection, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. During the inspection we spent time observing staff interactions with people including during activities and lunch time sittings.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Homefield House, one person told us, "I feel safe here, I sleep here, it's nice and it's warm". This was a view confirmed by relatives, one relative told us, "Oh yes, she (family member) is safe", another relative said, "She (family member) is 110% safe".

At our last inspection in February 2016 we identified people were not always safe from the risk of acquiring an infection. We made a recommendation asking the provider to ensure effective working practices were embedded in the home to protect people from this risk. During this inspection we identified that cleaning practices were more frequent and thorough. Suitable hand washing items such as hand soap and hand sanitiser were available to all and routinely used by staff. The provider had taken the action required to meet this recommendation and keep people safe from the risk of acquiring an infection.

People were safe from the risk of suffering abuse as staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns and felt confident to report any concerns to the registered manager, the provider and external agencies such as the local authority social services if required. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert and relevant reporting telephone numbers were clearly displayed in the registered manager's office. The registered manager was aware of their responsibilities and was able to identify when a safeguarding alert was required, completing these referrals in a timely fashion as necessary. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, people's moving and handling needs, their identified falls risk and any individualised risks identified such as risk of choking whilst eating. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. These also included the use of equipment aids such as hoists and slings which were required to support people safely. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Moving and handling equipment used to support people such as hoists and wheelchairs were available for staff to use and slings were allocated for each resident where required. This ensured the right equipment was always available and minimised the risk of cross infection. Risks to people's care were identified, documented and staff knew how to meet people's needs safely.

When accidents or incidents occurred these were documented fully and audited to enable the registered manager to identify if there were any actions which could be taken to prevent an occurrence. Staff completed the provider's adverse incident forms when an incident, accident or when the potential scenario

for an incident could occur. These detailed when and where the incident occurred, any witnesses, immediate action taken to manage the situation, steps taken to prevent the incident from re-occurring and were signed by the deputy or registered manager to ensure all available action was completed. It has been identified through these processes that a resident was becoming more increasingly agitated over what they believed was an invasion of their privacy by other people living in the home. The incidents were documented thoroughly and we could see that steps had been taken to try and minimise this person's distress by taking positive action such as rearranging living room furniture. This process to manage this situation was on-going at the time of the inspection however we could see that appropriate action was being taken to minimise future incidents between residents.

There were robust contingency plans in place in the event of an untoward event such as fire, flood, staff shortages and accommodation loss due to these events. Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home. These provided an easy to follow guide for staff and emergency personnel. The PEEPS included information regarding people who required additional assistance due to their complex needs in the event of a fire. If rooms were no longer suitable for habitation then people would be moved to a hospital or other homes within the county to ensure continuity of care. These plans allowed for people to continue receiving the care they required at the time it was needed.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Professional registration documents for nurses were available and updated to show they remained registered in order to provide nursing care. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Most people, relatives and staff we spoke with felt there were sufficient numbers of staff deployed in order to meet their needs. One person told us, "I know the staff, yes, I do think there's enough", another person said, "Yes, I think so". Most relatives confirmed this view, one told us, "Yes, there's enough staff, if you want anything they will do it". One relative told us that if there was a drop in staff numbers, such as in the event of last minute staff sickness, their relative would still receive the care they required. This relative said, "Sometimes they are a bit short staffed but they (staff) don't miss out on anything". Staff told us they felt there were sufficient numbers of staff deployed and if someone were unable to work due to last minute reported sickness they would work as a team in order to ensure all people's needs were met. Staff also said the registered manager and team leaders would assist if required in order to support the existing staff team with tasks such as assisting people at mealtimes.

The registered manager identified the staffing levels consisted of one nurse and six staff during the day with one nurse and three staff working during the night. Records and observations during the inspection showed that there had been deployment of sufficient numbers of staff to meet people's needs safely. Where shortfalls in the rotas had been identified these had been supported by the existing staff team offering to complete these shifts as overtime and the occasional use of agency staff. Staffing levels were reviewed by the registered manager when it was identified there had been a change in the level of people's needs so were adaptive to meet people's needs.

People living at the home received their medicines safely. Nurses received additional training in medicines management, and records showed that electronic medicine administration records (eMARS) were correctly

completed to identify that people received their medicines as prescribed. Nurses were also subject to competency assessments to ensure medicines were managed and administered safely. Nurses ensured the administration and management of medicines followed guidance provided by the Royal Pharmaceutical Society.

Guidance was provided in people's eMARS for nurses on when the use of additional medicine would be appropriate. This is referred to as 'when required' medicines and can include medicines to manage pain which are not required frequently, medicines associated with relieving constipation and oxygen to aid particular breathing conditions. We saw that appropriate information was provided as to when this additional medicine would be required and was followed appropriately.

Medicines were stored, administered and disposed of correctly. There was a medicines fridge which was kept at the appropriate temperature. Records confirmed a safe temperature was maintained. The provider used a nationally recognised policy to ensure that controlled drugs were managed effectively. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. The registered manager undertook monthly audits in all area of medicines management including the controlled drugs stocks to ensure people were receiving their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

People's relatives we spoke with were positive about the ability of staff to meet people's care needs. Relatives said that they felt staff were trained and had sufficient knowledge and skills to deliver care. One relative we spoke with said, "They (staff) seem to be capable", another relative told us, "I know they're (staff) more than equipped to look after (family member)".

At our last inspection in February 2016 we identified the home had not always been decorated or adapted in a way to support those people living with dementia to live as independently as possible. We made a recommendation that the provider sought advice on how to develop a dementia friendly environment which would meet people's needs. At this inspection we saw action had been taken to increase people's ability to move independently around the home, handrails were painted contrasting colours to the walls to enable people to have a focal point to enable them to walk safely within the home. There were also pictorial signs to assist people in identifying the different areas of the home such as communal areas including dining rooms and private areas such as bathrooms and toilets. The provider had taken action to ensure people were supported to move around the home safely. The provider was also due to commence building works shortly after the inspection which would lead to a redecoration of the home. These works were designed to ensure the further development of a dementia friendly environment for people living at Homefield House.

When people had been assessed as not having the capacity to make key decisions about their care, the provider had not always documented actions taken in people's best interests. 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager showed a comprehensive understanding of the Safeguards which was evidenced through the appropriately submitted applications and authorisations. Staff were not always able to clearly identify the principles of the MCA however people told us and staff demonstrated that they complied effectively with the MCA by offering people choices with their day to day care. Staff spoken with understood why Deprivation of Liberty Safeguards were required.

However for people who were no longer able to make decisions regarding their care the registered manager had not ensured that the appropriate processes had been followed to make decisions in people's best interests. Best interests decisions are made in conjunction with people close to the person the decision is being made on behalf of to ensure their needs are met fairly and any action taken is for the benefit of the person. For some people applications made to deprive them of their liberty had not always been discussed

with relevant persons and documented fully as being in their best interests. Other people had been identified as not having the capacity to agree to their personal care however no best interests' decision process had been followed to ensure the care provided was in the person's best interests. We brought this to the attention of the registered manager who identified these had been the responsibility of the deputy manager to complete who had left days prior to the inspection. However immediately following the inspection the registered manager ensured the best interests discussions with relevant parties were held and the results documented accordingly.

People were assisted by staff who received a thorough and effective induction into their role at Homefield House. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. New staff were required to complete an induction which was based on the Care Certificate. This is a structured induction programme which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support.

The provider had identified training which they felt was essential for staff to complete to enable them to provide care and ensured training refreshers were completed when required. Staff spoke positively of the training provided, one member of staff told us, "(There's a) lot of it and we seem to learn something every time", another member of staff said, "The training is constant…there's always training and there's also opportunities to do more like, there's one for bereavement". As a mandatory package staff had undergone training in areas including infection control, health and safety, moving and handling, safeguarding adults and first aid. Staff were also supported to complete training in the following areas, the MCA, management of accidents and sudden illness, allergen awareness, dining with dignity and person centred care. Nurses were also supported to undertake training in specific areas which enabled them to maintain their professional registration. This training included specific medical tasks such as, venepuncture (this is the procedure of interesting a needle into the vein), male, female and suprapubic catheterisation (processes for managing people's continence concerns) pressure ulcer prevention and treatment and the management of percutaneous endoscopic gastrostomy (a tube placed directly into a person's stomach through which they can receive, food, water and medication).

People were assisted by care staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop their skills and abilities. Supervision and appraisal records were detailed and individualised. During these processes issues of importance to both the supervisor and member of staff were discussed. Most staff told us and records confirmed supervisions occurred approximately every three months and were used as a way to identify if staff required or wanted to complete any additional training to support them in their role. Staff told us they were able to speak to their team leader or registered manager at any time if they required additional support. Processes were in place so that care staff received the most relevant and current knowledge and support to enable them to conduct their role effectively.

People and relatives were complimentary about the food provided and some people living at the home were supported by staff during meal times. One person told us about the food, "The food is good and there is usually something I like for lunch. The food is nice and there's a choice", another person said, "It's very nice food. I had a lovely meal". Relatives also spoke positively and identified their family members received specialised diets which met their individual needs, such as pureed diets. One relative told us, "The food is good, its puree'd for her. It tastes nice, I've tried it ". Another relative said, "it's a lovely menu, I'd like to come and stay! There is a different menu every day and she has a choice of things…the chef has always said, if there is nothing you want on the menu to let her know and she will do something special".

People were supported at mealtimes by staff who were patient and attentive to their needs. We saw staff were flexible in their approach when supporting people to ensure they were offered every opportunity to enjoy their meals. We saw one member of staff sat alongside one person supporting them to eat, they were patient and gentle in their approach and gave the person time to eat what was provided. Lunchtimes were a relaxed and unhurried occasion. Where one person did not want their lunch staff approached them on a number of occasions to see if they had changed their mind. Whilst they continued to refuse to eat staff encouraged them to drink as it was a hot day and we saw this person was provided with sufficient drink in order to meet their hydration needs. People had drinks readily available to them and cakes and biscuits were regularly offered to support people who may not always be willing to eat a main meal. Snacks such as sandwiches, smoothies, fruits and yoghurts were available to people day and night in the event they wished to have something additional to eat.

The chef spoke passionately about the role they completed and about the menu provided. They knew who had a range of specific dietary needs such as those who required a diabetic, pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained a visual appeal and was separated on the plates to allow people to identify what they were eating.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of illness could be identified. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Records showed that these were being completed showing minimal variations in weight suggesting they were supported to eat and drink sufficient amounts to maintain a healthy weight. Professional health care advice was sought and followed by staff which was evidenced during the interactions with the staff. For example some people living at the home could exhibit behaviour which could challenge others, this placed them, staff and other people living at the home of risk of injury or distress. We could see staff appropriately sought professional support and guidance from other professionals such as the older persons mental health team when situations arose. This was sought to identify whether or not there was any additional action the home could take to meet people's needs. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to support staff on how to manage people living with certain conditions, such as epilepsy. Care plans detailed what the triggers and physical symptoms of these episodes were, what action should be taken and which health and social care professionals should be made aware. Records showed that staff were aware and knowledgeable on what action to take in the event of medical episodes and were documenting these accordingly.

Good

Is the service caring?

Our findings

People were supported by staff who were motivated to deliver care in a gentle and caring manner. People and relatives confirmed that support was delivered by caring staff. One person we spoke with told us, "The staff are caring and kind." Another person told us about the staff, "The staff – they're very good, very caring". This view was shared by relatives we spoke with, one relative told us, "It's fantastic here. The staff are wonderful."

Positive and caring relationships had been developed by staff with people. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people.

For people who were unable to verbally communicate guidance was provided to staff about the changes in body language or facial expressions to identify whether or not people were happy or if they required additional support. This guidance included the importance of engaging and maintaining eye contact and offering physical touch as a way of interacting with people. We could see this guidance was being followed by staff during the inspection.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Guidance was provided in people's care plans to help staff identify when people who were unable to verbally communicate were distressed. This included the facial expressions and physical behaviours displayed and the actions to take during this period of unhappiness. One person was seen to be distressed during the inspection calling out for a family member. Staff were kind, compassionate and gentle with their approach to this person. Where environmental factors had been identified as potentially adding to people's distress steps were taken to minimise any potential impact. For example some people at the home would become upset when they watched their family members leave the home. As a result a skyline mural sticker was placed over the glass doors, this meant once people's family members were in the foyer they were no longer visible to people living in the home. This prevented people becoming overly distressed and upset.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people to engage with them. When communicating staff would often gently place a hand on people's arms to communicate that they were being spoken with. We saw that people were comfortable and actively sought this physical contact with staff and visitors to the home. Friendly conversations were held whilst staff and people chatted, held hands and interlinked arms whilst they moved around the home.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make

decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day. Care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in an office to protect confidentiality. During the inspection staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included making sure people were suitably clothed and had their modesty protected when they were assisted with their personal care. People were provided with personal care with the doors shut and curtains drawn to protect their privacy. Relatives we spoke with told us staff treated their loved one with respect, one relative told us, "If the door is shut they (staff) always knock (before entering), another relative said, "They're (staff) alright about dignity and privacy…they knock before coming into her room". Staff were seen to ask people before delivering or supporting with the delivery of care.

People were also respected by having their appearance maintained. Attention to appearance was important to people and noted in care plans. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked. We saw staff regularly supported people to maintain their appearance and ensured they were appropriately dressed. One member of staff was seen to gently stroke a person's hair whilst placing it into a tidy hair style for her, the gesture was affectionate and kind. Another person was seen by staff to becoming warm whilst they walked around the home, staff gently suggested to this person they may wish to remove their jumper as it was a hot day. This suggestion was met with a humorous and cheeky response from the person who agreed they were becoming too warm. Another person was seen to have a runny nose, staff identified this and gently guided the person to get some tissue to maintain their appearance. Staff were able to recognise people's want and need to be smart and well-dressed and ensured they offered support in a unobtrusive and caring way.

People were supported to maintain relationships with friends and family who were important to them. Friends and relatives were able to visit their loved ones without restrictions and were welcomed to the home by staff whenever they were present. One relative told us, "I come most days and can stay as long as I like", another relative said, "I'm here most days and it's no problem when I come", and another relative told us, "I come every day because I want to and I'm always made to feel welcome".

People had been supported to ensure their wishes about their end of life care had been respected and documented accordingly. Care plans provided personalised information for people regarding the support they required and their wishes about where they wanted to be. Care plans detailed the healthcare professionals who were required to provide assistance during this time. These plans were reviewed monthly to ensure that they were current and reflected people's latest wishes, needs and requests.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plan. People not able or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided. Relatives confirmed this occurred, one relative said they were involved in planning their loved ones care in conjunction with other family members, another told us, "I'm involved in her (family member's) care plan". The provider sought to provide a range of activities for people to participate in. A visitor to the home told us, "I think it's a nice home, they seem to be doing lots of activities…they (people) do seem to do quite a few activities which is nice to see".

People's care needs had been assessed and documented by staff before they started receiving care. These assessments were undertaken to identify people's support needs and care plans developed outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in annual reviews to ensure people received personalised care. One relative told us in relation to reviewing their family members care plan, "Usually there is a care plan review annually."

The provider sought to engage people in meaningful activities. Care plans detailed people's hobbies and previous enjoyments to help staff to encourage people to participate in as broad a range of social activities as possible. Care plans detailed people's particular social interaction needs and the need for activities to be completed with people on a daily basis. For people being nursed in bed we saw that daily activity suggestions were provided to enable staff to ensure people received social interaction. This ensured they remained engaged and had interest in their daily lives. We saw staff were following this guidance and ensured all people living at the home had some regular interaction to ensure their on-going wellbeing. For some people living at the home their care plans detailed that they enjoyed listening to particular genres of music. During the inspection we saw these people's favourite types of music were playing which was something they were known to enjoy. People, including those nursed in bed were also encouraged to participate in a number of sensory activities. This would include massage and aromatherapy. A massage therapist visited the home weekly to provide head and hand massages to people to provide engagement and relaxation.

The home had an activities coordinator who had previously worked as part of the care staff team in the home so had a good personal knowledge of people and their preferences. They worked three days a week for a total of 16 hours a week. When they were not present in the home staff told us that they left activities for them to complete with people. The activities coordinator sought to ensure people were engaged in activities and meaningful occupation whenever they were not present.

A typical week activities rota was viewed which had activities from Monday through to Friday. This included both internal activities such as reminiscing, pamper sessions, board games, arts and craft as well as external visits such as attending a local country park. External agencies were also encouraged to visit the home to encourage people to experience new and different situations. This included animal therapy where a petting zoo would visit the home, a therapy dog who would visit people in their rooms and musical groups. Staff

and the activities coordinator had identified that people particularly enjoyed the animal visits and had expanded the range available to them. This included other groups and charities who could bring not only animals such as hedgehogs, rabbits and guinea pigs to the home but other more unusual creatures such as geckos, lizards, stick insects and tarantulas. The home also had a cat which was well loved by people living at the home and provided a comfort and point of interest as they interacted with him.

Most people we spoke with were positive about the activities provided to them and we could see family and friends were able to participate in activities to further encourage people to engage. These included internal activities such as Valentine Day lunches, Father's Day fry ups, street parties in 'The Street' (the home's large central corridor) and external trips which included visits to an aquarium, a car museum, boat trips on the Solent and day trips to a number of different country parks. One relative told us, "There are some very good outings and some activities here", another relative said, "They (staff) take them (people) out on outings about four to five times a year. I go with my wife to push her around, we've been to Southampton, Winchester, Birdworld. There's parties in The Street and singers about once a month, maybe more. Staff will do some singing too. They do things mainly in the unit, they make things, drawings, puzzles. The activities coordinator comes into the unit to do things or sometimes the staff do it"

During the inspection we saw people engaged in completing jigsaws, playing cards, drawing, arts and crafts including making cards and people were supported to walk around the garden and enjoy the good weather. All staff working at the home took a group approach to activities to ensure people were engaged, mentally stimulated and enjoyed an interesting life.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the manager to address any concerns. One relative told us, "I feel like I could raise any issues to the current manager. There are resident and relative meetings occasionally but I've never been – wrong time of day." The provider's complaints procedure was available in the foyer which was accessible to visitors and relatives. This listed where and how people could complain and included contact information for the provider and the manager who could be contacted at any time.

The provider's policy offered advice and guidance to people, relatives and visitors to the home regarding how they would be able to raise a complaint, the timescales for any response to such a complaint and how to raise complaints with the local authority and local government ombudsman (LGO). The LGO is a free, independent and impartial agency which can investigate complaints about adult social care providers.

Complaints were recorded on the home's computer system so they were accessible to review to identify trends or repeated incidents involving people or staff. One formal complaint had been received since the last inspection. We could see the complaint had been raised, investigated by the registered manager and steps taken to address the cause of the complaint. This had been responded to by both the registered manager and the provider appropriately as per the provider's policy.

Good

Is the service well-led?

Our findings

The registered manager sought to achieve an open, honest and supportive culture amongst all staff, people and visitors to the home. People and relatives recognised and knew who the registered manager was and spoke positively of their ability to manage the home, one relative told us, "The manager is top notch. She's very dedicated and even comes in on her days off". People and relatives told us they were happy with the quality of the service provided. One relative told us, "I'm more than very happy. I don't want her (family member) to move from here. And the family agrees. It's like home from home."

The registered manager was keen to promote an atmosphere where people felt they were receiving care in a homely and family environment. Relatives we spoke with told us they felt Homefield House provided a homely environment for their loved ones. The home had a philosophy of care which had been developed by the provider and was displayed for people to view. This included the standards of care that people should expect to receive whilst living in the home. Wellness, happiness and kindness were identified as key words which were integral to the delivery and the receipt of care people received.

Staff were able to demonstrate they knew the provider's philosophy of care and the values of the registered manager who wanted Homefield House to feel like a home. One member of staff told us, "(the visions are) Kindness, wellness, caring, it's how we'd want to be treated and if they (people) were our family members how we would want them to be treated". Another member of staff said, "(treat people) Like they're in their own home with dignity and respect and like the family we are all are here", another member of staff told us, "We do the best for them (people) as we can, they come first, no matter what".

The registered manager was a visible presence to relatives and staff. People and relatives told us they were all able to recognise who the registered manager was and felt they were very visible in the home. Staff said that they were able to approach the registered manager and were confident that they would be proactive in dealing with issues raised, all felt supported as a result. They told us the registered manager was available to them if they required support or guidance and were actively involved in the day to day running of the service. One member of staff told us, "Yeah (feel supported)…she (registered manager) is there and if she's needed she'll help". The registered manager also provided people with her contact telephone number and promoted an 'open door' policy which meant they were always available to people. The relatives we spoke with all said the registered manager approachable and available to them.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance.

The quality of the service people experienced was monitored through regular care plan reviews, and residents and relatives meetings as well as annually completed surveys. The last residents meeting had occurred 23 March 2017 and during this meeting people were asked whether the food and menu met their needs and preferences, if people felt safe living in the home, if they liked the staff and if there were any

activities people wished to participate in. During this meeting people spoke positively about living at the home. The provider was due to send out questionnaires to people and their family to ask for their feedback on the quality of the service provided. At the last survey completed in 2016 only five people had responded to the questionnaire. Two requested more variety to the activities available so new memory boxes were provided for people to fill with items that were personal and meant something to them and a volunteer was brought into the home to help people become involved in reminiscence activities. This is a useful activity for people living with dementia as it allows them to experience feelings of familiarity and comfort when they can identify items which have held previous meaning for them such as photos.

There were planned dates for relatives meetings to take place every three to four months in 2017. The last attended relatives meeting had taken place on 9 June 2016. During this meeting the registered manager provided feedback on the results from a trial which they had announced at the February 2016 meeting where they would be moving staff to work in all different units within the home. This was felt to be a practical way for staff to obtain knowledge of everybody's individual needs and preferences. Staff had not been happy with the trial and relatives were informed they would be returning to the system with dedicated staff in dedicated units. Relatives were informed of upcoming events should they wish to participate and encouraged to give feedback or raise their concerns.

The provider also completed a number of quality assurance audits at the home to monitor the service provision which were included under the heading of 'Quality Programme'. The provider's policy identified the frequency and type of these quality assurance processes which included bi-annual quality reviews conducted by the provider's quality team and two monthly management reviews completed by the area manager. The registered manager also completed a number of monthly audits which monitored the quality of service provision.

These quality audits were used to assess the quality of care by reviewing care plans and outcomes, medication, control of infection, the environment, catering and people, care staff and professional visitors feedback. These audits were then used to create actions which had allocated owners and timescales for completion to ensure that the home was meeting the required standards of the regulations.

The last quality audit had been competed on 2 May 2017 by the provider's quality who then produced a report of their findings under the relevant headings of Safe, Effective, Caring, Responsive and Well-led. Actions where then allocated for completion to ensure on-going improvements were made. During this audit it had been identified that people were to be supported to access the garden at any time and people's topical medicines administration records were to be completed fully and consistently signed. Topical medicines are prescribed creams which include barrier creams and emollients which protect people's skin from the risk of pressure ulcers. During this inspection we saw this work had been undertaken and the home were now meeting these identified areas.

During an operations manager visit on 3 April 2017 it had been identified that there were areas of damage in a visitors toilet which could present a risk of injury or infection control, this work to repair and replace had been completed by 3 May 2017. It also identified that a nurse meeting was to be held as soon as possible which was organised for the 18 May 2017. These processes were effective in identifying areas of concern, allowing for positive action to be taken to address and improve the quality of the care provided to people.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home which evidenced staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the registered manager, staff and people were

friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.