Mission Care

Homefield

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 22, 23 and 25 September 2015. At our previous inspection in March 2014 we found the provider was meeting the regulations in relation to the outcomes we inspected.

Homefield provides accommodation, nursing and personal care for up to 44 older adults in Bickley, Kent. At the time of our inspection the home was providing support to 41 people. The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not always been identified or properly assessed, and action had not always been taken to manage risks safely. People were not always protected from the risk of malnutrition because staff were not always aware of who required fortified diets, and the monitoring by staff of risk areas did not always meet the

Summary of findings

requirements stated in people's care plans and risk assessments. We also found breaches which relate to good governance of the service as the quality assurance processes used within the home had not identified these issues and the provider was unable to demonstrate that appropriate action had been taken in response to an audit of the service's electrical system. CQC has taken urgent enforcement action in response to these concerns. We are closely monitoring the service and require the provider to submit information on a regular basis to assure us of the safe running of the service.

There were procedures in place to protect people from the risk of abuse. Staff had received safeguarding training and were aware of the action to be taken if they suspected abuse had occurred. However the provider had not consistently followed their procedures when an allegation of abuse had been raised. You can see the action in respect of safeguarding adults that we have asked the provider to take at the back of the full version of this report.

Appropriate recruitment checks were in place and staff received support through regular training and supervision. People and relatives told us that staff were kind and considerate, and treated them with compassion. However, there were not always enough staff to meet people's needs. You can see the action in respect of staffing that we have asked the provider to take at the back of the full version of this report.

Medicines were safely managed and administered, but some medicines had been stored in an area where temperatures were not regularly checked, and one staff member responsible for administering medicines had not received training in that area from the provider. Arrangements were in place to ensure people consented to their care and treatment, or that decisions about their care were made in their best interest, in line with the requirements of the Mental Capacity Act 2005, although we found some examples of mental capacity assessments having been recorded that were not decision specific. The provider took action to address these issues during our inspection.

People and relatives told us that they were involved in their care and that their privacy and dignity were respected. There were arrangements in place to comply with the Deprivation of Liberty Safeguards and people were aware of the procedure for raising a complaint. Staff were aware of people's individual needs and preferences, and we observed staff supporting people in a caring and considerate manner. People and staff told us that the registered manager listened to them and took action to address their concerns, and we observed example of people receiving good quality care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people had not always been identified and action had not always been taken to manage them safely.

Staff were aware of the potential signs of abuse and of the action they would take if they suspected abuse had occurred, but the provider's procedure had not always been followed in response to abuse allegations.

Appropriate checks had been carried out on staff before they started work for the service but there were not always enough staff to meet people's needs.

Medicines were safely administered but there were risks in the way some medicines had been stored. These issues were addressed during the inspection.

There were arrangements in place to deal with foreseeable emergencies.

Is the service effective?

Requires improvement

The service was not always effective.

People told us they had enough to eat and drink and that they enjoyed the choice of meals on offer, but the risk of malnutrition had not always been adequately managed by staff.

Staff had received training relating to the requirements of the Mental Capacity Act 2005 and were aware of the need to gain consent from people when offering support.

Staff received training in areas the provider considered mandatory in order to meet the needs of people living in the home. Staff also received supervision on a regular basis and felt well supported in their roles.

People had access to a range of healthcare professionals when needed to ensure their needs were met.

Is the service caring?

Good

The service was caring.

People told us that staff were friendly and considerate and we observed staff treating people with kindness and compassion.

People were consulted about their care needs and were involved in any decisions made about the care they received.

People told us that staff treated them with dignity and respect, and that their privacy was respected.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

Care plans did not always indicate people's preferences in the way they liked to be supported or indicate what each person may be able to do for themselves, in support of their own independence.

Staff had knowledge of people's life histories and the way in which liked to be supported. People were supported to engage in a range of activities that met their needs and reflected their interests.

There was a complaints policy and procedure in place and people were aware of how to make a complaint.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The provider had quality assurance systems in place but these were not always effective and did not always identify issues or drive improvements.

People and staff told us that the service was well run and had an open culture, and that their views were taken into consideration.

There were regular meetings with people and their relatives and the manager took action to make improvements from the feedback they received.

Homefield

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 functions. This inspection was planned to check whether the provider is 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 unannounced inspection took place on 22, 23 and 25 September 2015. The inspection team on the first day consisted of two inspectors. One inspector returned to the home on the second and third days to speak with the provider, staff and people using services, and to examine records related to the running of the home.

Prior to the inspection we reviewed the information we held about the service and the provider. This included notifications received from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. We also contacted the local authority responsible for monitoring the quality of the service. We used this information to help inform our inspection planning.

During the inspection 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. We spent time observing the care and support being delivered.

We spoke with four people using the service, seven visiting relatives, a visiting GP, seven members of staff and the Clinical Director. We looked at records, including the care records of ten people using the service, six staff members' recruitment files, staff training records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us that they felt safe living in the home and that they were happy with the care they received. One person said "I have no worries. I'm quite happy here." A relative told us "My husband is safe living here; the staff are good with him." However, despite positive comments from people and relatives about safety in the home, we found that risks to people's health and safety had not always been correctly identified and that action had not always been taken to manage them safely.

Records showed that one person had lost significant weight between February and April 2015, but whilst they had been assessed as being at high risk of malnutrition, no action had been taken at that time, in line with the guidance used by the provider. A proposal to make a delayed referral to a dietician was recorded in their care plan in June 2015, but there was no record of a dietician having visited and staff we spoke with told us the referral had not been made. A referral to the dietician was made during our inspection in response to the concerns we raised.

In total we found that action had not been taken to safely monitor or mitigate the risk of malnutrition for five people living at the service. For example, a visiting dietician had recommended fortnightly weight checks for one person over a two month period, but records showed that only two checks had been made over the following eight weeks. During that time the person had lost further weight. The dietician had also recommended monitoring another person's food and fluid intake, but staff we spoke with told us they were not currently doing so. In a third example, we found one person's malnutrition risk assessment had not been reviewed on a monthly basis in line with the provider's requirements. Their weight had also not been checked for a period of more than seven weeks despite significant previous weight loss putting them into the high risk category.

Staff were also not always aware of people's food allergies putting them at risk of harm. For example one person's care plan identified them as being allergic to gluten and eggs but kitchen staff only identified their gluten allergy when questioned. We saw menus included meal options containing eggs which could have been offered to the person with the allergy, putting them at risk. We spoke to the provider about this and a list of people allergies was put on display in the kitchen for staff to refer to during our inspection.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took urgent enforcement action in response, and the provider is now required to send us regular information about the safe running of the service. You can also see the action we took at the back of the full version of the report.

There were procedures to protect people from possible harm. The service had a safeguarding adults policy in place for staff to refer to and training records showed that staff had undertaken safeguarding training within the last twelve months. Staff we spoke with confirmed that this training was refreshed annually. They were aware of the different potential types of abuse that could occur, and knew what action they would take if they suspected someone was at risk of abuse. Staff were also aware of the provider's whistle-blowing procedure and who they would escalate their concerns to if they felt action was not taken.

However, we found an example of an allegation of abuse that had not been recognised by the provider and which had subsequently been treated as a complaint. This meant that the local safeguarding team had not been made aware of the allegation, in line with the provider's procedure and pan-London requirements. This meant that there was a risk that people may not be protected from the risk of abuse as allegations were not always raised for consideration with the appropriate authority.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Medicines were safely managed but there were risks in the way that some medicines had been stored in the home and staff had not always received training from the provider in the administration of medicines. We observed medicines being administered in a safe way and at the appropriate time by a registered healthcare professional; although they confirmed that they had not received training from the provider to do so. We spoke to the provider about this and they arranged a training session for the staff member to address this concern.

Medicines were stored securely and people's medication administration records (MAR) had been correctly completed by staff with no omissions recorded. A

Inadequate

Is the service safe?

photograph of each person was kept with their MAR and known allergies were also recorded to reduce the risks related to the administration of medicines. However, we found that some medicines were stored in an area where temperatures were not regularly checked and therefore the provider could not be assured that they had been stored within the recommended temperatures to remain effective or safe for use. We brought this to the attention of the provider who arranged for the medicines to be stored in a temperature checked environment during our inspection.

There were safe recruitment practices in place and appropriate recruitment checks were conducted before staff started work for the service. Staff files contained a completed application form which included details of their employment history and qualifications. Each file also contained evidence confirming references had been sought, proof of identity reviewed and criminal record checks undertaken for each staff member. Appropriate checks had also been made of agency workers when used to ensure they had the right skills to work for the service.

Relatives we spoke with had mixed views on staffing levels in the home. Two relatives commented that there could be more staff, particularly at the weekends, although all of the people and relatives we spoke with told us that there were enough staff to ensure people were safe. One relative told us "Staff respond quickly when needed." However, during one day of our inspection a staff member called in sick and cover could not be arranged. This resulted in staff on one floor not having time to get one person out of bed that morning and we saw that they were still in bed at 14:00. Whilst staff ensured the person's care needs were covered, the person's care plan indicated that they enjoyed joining in activities with other people in the home and therefore their social needs were not adequately catered for due to the staff shortage.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

There were arrangements in place to deal with foreseeable emergencies. Records showed the personalised emergency evacuation plans had been developed for each person using the service and staff had received fire safety training. Staff we spoke with confirmed they had attended fire drills and could describe the action they would take in the event of a fire, or an emergency.

Requires improvement

Is the service effective?

Our findings

People and relatives we spoke with told us they were happy with the choice of meals on offer within the home. One person told us "I told them I'd like more fish and it was arranged". Another person told us "Lunch was lovely and there was plenty." One relative whose loved one required a soft diet said "The pureed food is good and presented nicely."

However we found that people's nutritional needs were not always being met. For example, staff we spoke with on one floor of the home told us that fortified milk used to supplement some people's diets had not been prepared and included as part of their breakfast meal on 25 September 2015, in line with their assessed nutritional needs. We spoke with the person in charge of the kitchen on that day who told us they were not aware of the need to provide fortified milk for people on that floor so they had not done so.

A list was on display in the kitchen of people requiring fortified meals and drinks but it did not include some people who had been assessed as requiring these supplements according to their care plans. Staff we spoke with were unable to identify all the people requiring fortified meals or drinks which meant some people were at risk of malnutrition because staff supporting people were not always aware of their dietary needs.

These issues were a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action in response, and the provider is now required to send us regular information about the safe running of the service. You can also see the action we took at the back of the full version of the report.

We observed people being supported during a lunchtime meal. Some people required support from staff to eat whilst other people were supported to eat independently through the use of adapted crockery. The support staff offered was unrushed and interactions with residents were friendly and caring.

People and relatives told us they thought staff had the right skills and knowledge to undertake their roles. One person said "The staff are fine." A relative told us "The staff have had the right training. They know what they're doing." A member of staff told us "I've had a lot of training since joining; they make sure we're up to date."

New staff members were required to complete an induction programme which included mandatory training and shadowing experienced staff members. Staff we spoke with told us that they were then shadowed by an experienced member of staff before working alone in order to ensure they had the right skills for the role. They told us that they felt their induction was helpful in learning the requirements of their role.

Training records showed that staff had completed training in areas which the provider considered to be mandatory which included Moving and Handling, Dementia Care, Fire Awareness, First Aid Infection Control, Safeguarding of Vulnerable Adults, The Mental Capacity Act 2015 (MCA), and Health and Safety.

Staff received supervision on a regular basis which included an annual appraisal. Staff we spoke with told us they felt well supported through their supervision and that any issues they raised during the process were dealt with appropriately.

Staff told us, and records confirmed that they had received training relating to the Mental Capacity Act 2005, which protects people who may lack capacity to make decisions about their care or support. They were also aware of the importance of gaining consent from the people they offered support to and we observed staff seeking consent whilst offering support during our inspection.

However, some improvement was required in the way decisions around capacity had been recorded. For example, whilst we saw evidence of people's capacity having been appropriately assessed relating to specific care decisions, we also found some assessments that were not decision specific and made reference to people having a general lack of capacity to make decisions about their care. Staff we spoke with confirmed that people were often able to make day to day decisions about their care and that they worked in such a way to ensure people's choices and decisions were respected. We spoke to the provider about the capacity assessments we had seen and they agreed to remove them from people's care plans as they did not follow best practice. Where decision specific assessments had been conducted, we saw that best interests decisions had been appropriately made, involving family members or healthcare professionals.

CQC is required by law to monitor the operation of the Deprivation of Liberty safeguards (DoLS). DoLS protects

Requires improvement

Is the service effective?

people when they are being cared for or treated in ways that deprives them of their liberty for their own safety. The provider understood the process of requesting a DoLS authorisation and we saw appropriate referrals had been made and authorisations granted for some people to ensure their freedom was not unduly restricted. However, some people's care records included an assessment to determine whether a DoLS application was required which did not fully reflect current guidance on when DoLS may apply. We were unable to speak to the Registered Manager about this at the time of our inspection as they were on annual leave, but minutes from a recent meeting showed that they were aware of the issue and the current requirements under which DoLS may apply, and were in the process of changing the forms.

Records showed that most people had access to a range of healthcare professionals in order that they maintain good health including a GP, Podiatrist, Dietician and Dentist. We spoke with a GP who visited people at the service during our inspection and they told us that staff "go beyond the call of duty," in their support of people. They said that staff were knowledgeable about people's conditions and that they made prompt referrals when required.

Good

Is the service caring?

Our findings

People told us that staff were caring and compassionate. One person told us the staff were "very nice" and a visiting relative described the service as being "open and friendly". They told us "the door is always open; we can visit whenever we want." One staff member told us of the importance of respecting people's diverse backgrounds. They said ""I treat the residents the way I would want to be treated and I appreciate their differences."

Throughout the inspection we observed caring and respectful interactions between staff and the people they were supporting. Staff were relaxed and friendly when engaging with people, and offered support at a pace they were comfortable with. During the lunchtime meal we observed one member of staff offering a choice of two meal options to one person who had difficulty communicating verbally by showing them a plate of each choice so that they could indicate their preference.

Where people displayed signs of anxiety, staff were quick to reassure and calm them, and their actions were effective in doing so. One person described the staff as being kind and another person told us "They're always polite." A visiting relative told us "I'm grateful that the staff are all so caring."

Staff knew the backgrounds of the people they supported and were aware of the things that were important to them, and the way in which they liked to be supported. People and relatives we spoke with confirmed they were involved in making decisions about the support they received. One relative told us "We often talk about their care plan and I'm kept well informed." Another relative told us "many of the staff have been here for a while which is good because they know their needs"

People were provided with information about the service. Notice boards displayed information relating to the activities on offer as well as the provider's aims and values, and how to make a complaint of suggestion. People and relatives told us they could express their views about the care they received or their experiences of the service to the staff and that they felt listened too.

Staff described how they worked to ensure the maintained people's privacy and dignity, for example by closing people's doors while they provided personal care or knocking before entering and seeking people's consent to confirm they were happy with any support they received. Relatives confirmed they had no concerns regarding their loved ones privacy and dignity being respected One relative confirmed "Staff always ensure that the bedroom doors are closed when helping people in their rooms," and we observed staff working to promote people's dignity in this way during our inspection.

Requires improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us they had been involved in the planning of their care and that their views were taken into account when developing their care plans. A relative told us "We've been involved in the care planning and they review it with us regularly. The communication between us and the staff is very good." People's needs were assessed on admission to the home and individual care plans developed to address areas of need, including communication, personal hygiene, nutrition and mobility. Records showed that people's care plans were reviewed on a regular basis and reviews had been signed by people or their relatives to confirm their involvement.

People's care plans also contained some details relating to their preferred social activities, personal history, religious background and other things that were important to them, although in some cases this information was limited. Care plans did not always indicate people's preferences in the way they liked to be supported or indicate what each person may be able to do for themselves, in support of their own independence. These issues required improvement.

However, staff we spoke with demonstrated a good knowledge of people's life histories and were aware of their preferences within their daily routines. They could describe how they supported people to maintain their independence wherever possible, for example by brushing their own teeth as part of their personal care regime. We also observed examples of staff providing support that reflected people's preferences and encouraged their independence, for example whilst mobilising or being supported with their medication.

Relatives we spoke with also confirmed that people's individual needs and preferences were respected. One relative when describing the care provided to their loved one told us "This home suits her needs." Some people's rooms were decorated with personal belongings, including furniture in order to better reflect their personalities. People also had access to equipment which supported their independence such as hoists and wheelchairs where required.

People were supported to engage in a range of activities in support of their physical and mental wellbeing. We spoke to one of the two activities co-ordinators working at the service who told us that they had developed a programme of activities for people living in the home which included exercise sessions, bingo, pampering sessions and outings to a local café or other areas of local interest. The activities co-ordinator also told us that they undertook one to one sessions with people in their rooms if they were unable to attend sessions in a communal area. We observed positive interactions between staff and people during a reminiscence session. One relative told us of their loved one "He really enjoys the activities."

People and relatives told us that they knew how to make a complaint and we saw that a complaints procedure was on display for people within the home should they need to raise concerns. One relative told us "I would speak to the keyworker or the manager, but I've not needed to." Another relative told us that they had not formally complained as any issues they wished to raise could be discussed at regular residents and relatives meetings. They explained that they had raised an issue about the delay in getting a replacement blind in their loved one's bedroom and that the manager had promptly arranged for a replacement to their satisfaction.

Records showed that showed that complaints were clearly recorded where they had been raised and a record had been maintained relating to the investigation undertaken and any actions taken in response to the concerns raised.

Requires improvement

Is the service well-led?

Our findings

The provider had quality assurance systems in place but these were not always effective and failed to always identify issues or drive improvements. Audits had been conducted by staff and external contractors relating to areas which included people's care plans, medicines, and a range of health and safety checks within the home. Some of the audits we reviewed included records of the actions to be taken to address any deficiencies found, and we saw that these actions had been carried out.

However, audits of some people's care plans failed to identify issues with the care being provided which resulted in a lack action taken to address the concerns. For example, an audit of one person's care plan had failed to recognise a staff had not responded to the person having lost significant weight. In a second example, two audits of another person's care plan failed to note that the person was only being weighed on a monthly basis despite their care plan indicating weight checks should be made on a fortnightly basis due to an increased level of risk.

A five yearly inspection of the electrical systems in the home which had been conducted in 2011 by an external contractor indicated that the overall system was in an unsatisfactory condition and that various faults needed to be rectified promptly to bring the system up to standard. The provider was unable to demonstrate that any action had been taken in response to the inspection findings. However when we identified these concerns to them they took action to bring forward the next inspection so that the system could be reviewed again and any issues addressed.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action in response, and the provider is now required to send us regular information about the safe running of the service. You can see what action we told the provider to take at the back of the full version of the report.

Staff spoke positively about the registered manager and the support they received. One staff member described the manager as encouraging an open culture within the service to help drive improvements, saying "She is very committed. We all work hard here for the same goals; we want the residents to be as happy and as comfortable as possible." Another staff member told us "If you have any problems you can talk to her and she'll deal with them immediately." Another member of staff told us they felt improvements had been made to the consistency of the staff since the registered manager had taken up her post and described her as being "very supportive." We were unable to speak to the registered manager during this inspection but records showed that they had submitted appropriate notifications to CQC as required under their registration.

Staff told us that they took part in handover meetings between shifts so that any information relating to people's daily needs or changes in support could be shared with the new shift. Staff also told us that regular staff meetings took place which provided them with an opportunity to talk about any concerns they may have or areas within the service which may require improvement.

People were asked for their views about the service. The provider conducted an annual survey to gain feedback from people who used the service and relatives. The provider told us that the results from the 2015 survey had not yet been published as the survey had only recently been issued. We saw results from the 2014 in which indicated that the people and relatives thought positively about the care people received, with 100% of respondents indicating they would recommend the service provided.

Relatives we spoke with told us that the home had regular resident and relatives meetings where people were able to voice their views on how the service was being run. One person told us "They listen to any issues we raise during the meetings and will act, although sometimes it can take time for them to respond." Other relatives we spoke with were more positive and told us that improvements had been made in areas such as the activities on offer in the home or the recent purchase of more cantilever tables for use by people living in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Appropriate systems were in place but not always used to effectively investigate any allegation of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of staff were not always deployed.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way.** **(1)(2)(a)(b) Risks to people were not always assessed or steps taken to reduce risk.** **Regulation 12 (1)(2)(a)(b)**

The enforcement action we took:
An urgent Notice to Impose Conditions was served on 05 October 2015. The provider is required to send us information on a weekly basis to evidence the safe assessment and management of risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The Nutritional and hydration needs of service users were not met.** **Regulation 14(1)**

The enforcement action we took:
An urgent Notice to Impose Conditions was served on 05 October 2015. The provider is required to send us information on a weekly basis to evidence the safe management and review of risks to people in relation to their nutritional and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes in place to assess, monitor and mitigate risks were not operated effectively.** **Regulation 17(1)(2)(b)**

The enforcement action we took:
An urgent Notice to Impose Conditions was served on 05 October 2015. The provider is required to send us information on a weekly basis to evidence the effective management of systems to monitor and mitigate risks to people.