

## Livability

# Keefield

### Inspection report

Keefield Close  
Keefield  
Harlow  
Essex  
CM19 5SW

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Tel: 01279635933

Website: [www.livability.org.uk](http://www.livability.org.uk)

### Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

Keefield is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Keefield is a purpose-built care facility providing personal care and accommodation for 10 people. The service consists of two bungalows each accommodating five people. At the time of inspection nine people were living at the service.

There was 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 the last inspection, the service was rated Good. At this inspection we found the service remained Good.

We met and spoke to some people during our visit and observed the interaction between them and the staff. People were not able to fully verbalise their views and used other methods of communication, for example verbally, and through physical gestures or body language, electronic tablets and symbols.

People remained safe at the service. People had one to one staffing at all times. Safe recruitment procedures were in places to help ensure staff were suitable to work with vulnerable people.

Staff had a good understanding of risks associated with people's care needs and how to support them. Medicines were stored and administered safely, and people received their medicines as prescribed. Regular audits ensured medicines were managed in line with good practice guidelines.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. The management and staff team understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The staff had built strong relationships with people and treated people kindness and compassion and respected their privacy and dignity. People or their representatives, were involved in decisions about the care and support people received.

There was a friendly, relaxed atmosphere and staff were kind and attentive in their approach. People were provided with food and drink that met their individual needs and preferences.

People were supported to take part in a variety of activities and trips out based on their interests. End of life

care was co-ordinated and in the best interests of the person.

The registered manager sought feedback about the quality of the service provided from people and/or family members, staff and visiting health professionals. There was an on-going quality monitoring process in place to identify areas of improvement required within the service. Where improvements had been identified, actions were taken.

## 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 ●

This remains good.

### Is the service effective?

Good ●

This remains good.

### Is the service caring?

Good ●

This remains good.

### Is the service responsive?

Good ●

This remains good.

### Is the service well-led?

Good ●

This remains good.

# Keefield

## **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 checked 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 inspection took place on 12 January 2018 and was unannounced. One inspector undertook the inspection.

Prior to the inspection we looked at other information we held about the service such as notifications and previous reports. A notification is information about important events, which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection. The provider completed a Provider Information Return (PIR). This 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. We considered this during the inspection.

We observed the care and support provided to people who lived at the service. Most people had limited verbal communication and were unable to tell us in any detail about the service they received. We spent time talking with staff and observing how they interacted with people.

We spoke with the registered manager, the deputy manager, the cook and two support staff. We looked at the records of four people who used the service and two staff records. We also looked at rotas, audits, staff training and supervision records, health and safety paperwork, accident and incident records, complaints and compliments, minutes from resident and staff meetings.

# Is the service safe?

## Our findings

The service continued to provide safe care.

The provider had a safeguarding policy staff understood how to protect people from abuse and avoidable harm. Staff undertook training in how to recognise and report abuse and staff knew what action to take if they suspected people were being abused. Staff said they would have no hesitation in reporting any concerns to either the registered manager or external agencies, such as the local authority. One staff member told us, "I would go straight to the shift leader or the manager. If I was still concerned I would go to the local authority." People at the service were supported to keep safe and safeguarding had been discussed in a format people could understand at a residents' meeting.

People's individual equality and diversity was respected because staff had completed training and put their learning into practice. Staff completed an induction that included the provider's policies and procedures, equality and diversity and human rights as part of this on going training. For example, staff respected people's individual way of communicating.

People had risk management plans in place and staff worked within this guidance. We observed support being delivered as planned in people's support plans. Risk assessments were specific to each person and had been reviewed. The risk assessments promoted and protected people's safety in a positive way. These included mobility, nutritional risk, skin integrity and emotional wellbeing. These explained what the risk was and what to do to protect the individual from harm. We saw they had been reviewed regularly and when circumstances had changed. For example, care files included detailed mobility risk assessments and described in detail the best way to support the person to move safely.

People had risk assessments in place regarding their behaviour and we observed a staff member supporting a person that became distressed during an activity. They gently moved the person from the situation and distracted them with one to one support, which helped to alleviate their distress. Electronic care plans were used and staff had secure access to this information.

The service has a system to record, monitor and manage accidents and incidents and learn from these. Investigation procedures were in place regarding safeguarding, complaints or concerns, accidents incidents. The provider had an electronic system and all incidents were logged which enabled them to monitor actions, outcomes and learning from these incidents were completed.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system, personal emergency evacuation plans, water temperature checks and regular servicing and checks on equipment. A monthly health and safety check of equipment and premises was also in place and health and safety was an agenda item at all staff meetings.

The service followed the provider's policies and procedures in relation to the control and prevention of

infection and staff received training in infection control and food hygiene. Care files included any information required to manage infections that could affect people's health and wellbeing. We observed the use of personal protective equipment such as gloves and aprons during our visit. This meant people were cared for in a clean, hygienic environment. Infection control audits were completed by the registered manager to make sure safe practice was being followed.

During our inspection, we observed there were enough staff available to respond to people's needs. People had one to one hours in place based on their needs. Staff were meeting people's needs, supporting them and spending time with people. One staff member told us, "There is more than enough, and we have time with people. I support one person with their one to one time, they like to go out so we go out a lot." The provider continued to have safe and suitable recruitment processes in place for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. A new staff member confirmed they were unable to start work until satisfactory checks and employment references had been obtained.

People received their medicines safely from staff that had completed appropriate medicine training. Medicine practices and clear records were kept to show when medicines had been administered. People were prescribed medicines on an 'as required' basis. There were clear protocols in place to instruct the staff when these medicines should be offered to them and when additional support, for example further advice from the doctor was needed. Senior staff checked medicine records daily and monthly to ensure standards were being maintained. The provider had clear procedures for giving medicines covertly, in line with the Mental Capacity Act 2005. However, we did note one person was receiving their medicines in food and the registered manager had not fully completed all the documentation required to evidence the decision was made in the person's best interest. The documentation required was sent to us following this inspection.

# Is the service effective?

## Our findings

People continued to receive effective care and support.

People's needs were assessed in order to develop individual care plans in consultation with people, relatives, professionals, keyworker and through observation. Care plans reflected people's needs, choices and preferences. Staff and other health professionals supported people's health care and annual health checks were carried out by the community nurse or GP at the local surgery. Care is reviewed every six months or sooner if a change occurs.

Staff had received training to meet people's individual needs. The provider made sure the staff team completed training courses so staff had the right skills and knowledge to meet people's needs. Staff were complimentary of the training opportunities, telling us there was regular training offered. Training courses included, moving and handling, health and safety, mental capacity training, safeguarding awareness, palliative care, medication safety, food hygiene and the Care Certificate (a nationally recognised training course for staff new to care). New staff received an induction prior to commencing their role, to introduce them to the provider's values and policy and procedures. Staff received supervision and team meetings to provide the staff with the opportunity to highlight areas where support was needed and encourage ideas on how the service could improve. One new staff member confirmed they were currently completing the Care Certificate and had shadowed experienced staff for two weeks. A senior staff member told us, "I have just mentored a new staff member for two weeks and can remember what it was like when I started. We try to support new staff."

Handovers take place between each shift and are used to inform staff about any changes or updates from the previous shift. Staff told us the service was small and they worked as a team to support people effectively. One staff member said, "We all try our best to work together and people get good care." Another staff member said, "We encourage each other."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. Where people lacked capacity, the appropriate best interest processes had been followed.



People continued to be supported to have enough to eat and drink. Staff were aware of people's individual dietary needs and their likes and dislikes. Care records contained information about their food likes and dislikes. We spoke to the cook who told us they were working with the lifestyle worker to produce a pictorial menu; they had started photographing menu choices staff could use to promote choice. Advice where needed was received from the community dietician and speech and language therapists. Monthly weights were completed so staff could monitor any changes and liaise with appropriate healthcare professionals. In the care plans we looked at people's weights which were stable. Trained staff supported people who used the service that had a PEG and there were clear protocols in place. PEG stands for percutaneous endoscopic gastroscopy, which is a way of introducing food, fluids and medication directly into the stomach. When we spoke to a new member of staff, they confirmed only staff that had completed the training could support people. During the inspection we observed lunch was relaxed and staff were able to sit and support people at their own pace.

People continued to be supported to maintain good health. Staff ensured people attended scheduled appointments and check-ups. Each person had a hospital passport that included important information about how they communicated, what they liked and what they disliked.

Aids and adaptations were in place throughout the service. One of the bathrooms included a sensory bath, which we saw from people's records was popular. Bedrooms were decorated and furnished to meet the individual's choices and preferences, supported by the keyworker. A sensory garden and sensory room were available for people to use with support from staff.

# Is the service caring?

## Our findings

People continued to receive a caring service.

During our inspection staff treated people with respect and in a caring and kind way. Staff were friendly when providing support to people and had time to sit with them. We saw people looked relaxed, comfortable and at ease in the company of staff. We observed positive interactions and saw these supported people's wellbeing. One person told us, "I like the staff."

There was a positive and friendly atmosphere at the service and the staff we spoke with knew people well. A keyworker system was in place so people had a named person that took responsibility for the person's care and support. One staff member told us, "We go out together and make a list so [named person] can choose their own toiletries, we also attend reviews with people."

Staff communicated with people in an individual way and as stated in their care plan. In one person's care plan, it stated, 'I use touch when I want your attention'. We observed staff using appropriate communication with people. People were supported by staff to maintain their personal relationships. Families visited regularly and the registered manager told us families often visited together so they could chat and meet up while they visited their family members. Families were invited to attend review meetings and any special events at the service. There was a visitor's policy in place and visitors are welcomed in accordance with the person's wishes and preferences.

People had access to individual support and advocacy services. This helped ensure the views and needs of the person concerned were documented and taken into account when care was planned.

People's privacy and dignity was promoted. Staff told us they knocked on people's doors prior to entering their rooms. One staff member told us they would make sure doors were closed and people covered to protect their privacy and dignity. Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way. A dignity champion was in place on site to promote good practice and had a slot to discuss this at most staff meetings. We saw minutes from the last meeting where the champion had discussed this subject with all staff.

Staff undertook tasks and activities with people to encourage and support their independence. The deputy manager was the active support champion and alongside the life style worker encouraged staff to involve people as much as they are able with day to day tasks. For example, helping to keep their rooms tidy, shopping and cooking. The service also had volunteers that supported people with a cookery session.

Staff required password access to care plans which were held electronically. This meant people could be assured information about them was kept confidential.

## Is the service responsive?

### Our findings

The service continued to be responsive.

Care plans were person-centred and detailed how people wanted their needs to be met in line with their wishes and preferences, taking account of their social and medical history, as well as any cultural, religious and spiritual needs. Care plans provided clear and detailed information about the person's care and support needs, and identified what the person could do for themselves and what support staff should provide. Staff monitored and responded to changes in people's needs, for example, one person had previously attended a day centre no longer appeared to be benefiting from this. Staff told us what alternatives had been put in place for the person so they could still access the community. A staff member told us, "They love to be out shopping and eating out and we have seen the changes have improved their wellbeing." We saw the keyworker or lifestyle worker attended reviews with the person and their family and recorded an overview of how the person had been, what they had enjoyed and what was planned.

People living at the service continued to participate in a range of activities, including attending day centres, shopping, cinema trips, visits to the pub, train rides, arts and crafts, sensory sessions, trips into town, theatre trips and music therapy. Support was provided for people to attend the church of their choice. The registered manager recorded in their PIR, "Equal opportunities are given to meet individual needs, for example, spiritual needs whereby one of the service users attends a lively church service, supported on a weekly basis by a trained volunteer, and another attends a more traditional type church". Keefield's friends group continued to raise funds to support the service and were currently raising funds to continue to use the music therapy sessions.

People's communication needs were effectively assessed and met and staff told us how they adapted their approach to help ensure people received individualised support. The service placed a strong emphasis on observation and we saw during the inspection a staff member notice a person's body language and mood when they appeared not to be enjoying the activity. The lifestyle worker used pictures or an electronic tablet in meetings to assist people with communication. For example, at the last residents meeting they showed people pictures of food to communicate the intention to create a pictorial menu to promote choice when menu planning.

There was a complaints procedure in place and views, complaints or concerns were recorded, investigated and responded to appropriately. We saw although no formal complaints had been received the registered manager recorded and responded to any minor concerns. For example, we saw one minor concern related to the environment and an apology letter had been sent.

People were supported when making decisions about their preferences for end of life care. The service kept important information in yellow folders and this included advanced care plans and preferred priorities for care documents. The service maintains strong links with health care professionals and multidisciplinary meetings were held with health professionals, the person and relevant family members when decisions were made regarding do not attempt cardiopulmonary resuscitation (DNAR CPR). Staff had received training in

end of life care. In the compliments file we saw a comment made by an end of life co-ordinator which said, "Excellent approaches to end of life care, a pleasure to work with you."

## Is the service well-led?

### Our findings

The service continued to be well-led.

There was 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.

The registered manager continued to demonstrate effective leadership skills within their role. They promoted a positive culture that was open and transparent. Staff remained confident about approaching the registered manager and the deputy and felt supported. Their open door policy remained and both the registered manager and deputy manager were visible in the service. Since the last inspection, the manager had relocated their office to the main building next to the front door and this meant they were more accessible to people using the service and their family members. It was recorded on the provider's information return that this also, "Helps them in overseeing the work that is carried out."

Staff told us, "The registered manager is very approachable and we can talk to all the seniors if we have any issues." Another staff member said, "We can talk to them at any time, their doors are always open."

Staff attended monthly meetings where views and ideas were welcomed. Champions in areas such as dignity, active support and medicines were given opportunities to discuss their subject as learning opportunities for staff. At the last meeting dignity and active support was covered. The Service had clear aims and objectives that were in line with the provider's values and aims. These were understood by staff and put into practice, they understand their role and knew what was expected of them.

People were involved in decisions and changes regarding the running of the home. The service gathered people's views through a variety of different ways, such as resident meetings and key worker sessions. Relatives also met informally at the service and at formal meetings and reviews. A friends of Keefield meeting was also held to support the service through fund raising.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care. All incidents, accidents, complaints were logged onto an electronic system and shared with the provider who monitored actions taken, investigations and outcomes. We saw where a recent minor accident had resulted in discussions with the provider and further training had been identified for the staff team. The service and staff understood the need to share information relating to any incidents, accidents with all relevant parties. The service had an openness and willingness to learn from incidents, investigations and complaints in order to improve the quality of the service.

Records showed CQC was informed of incidents that the provider was legally obliged to notify them of. This showed us the registered manager was aware of their responsibilities in reporting events to CQC when

required.

The providers quality and practice improvement team visited the service every six months, one of the visits was announced and one unannounced. They carried out a detailed audit and any resulting actions were recorded on an improvement plan for the registered manager. We saw where the registered manager had completed actions and updated the plan.

The registered manager attended regular meetings with other registered managers to discuss best practice. Various speakers were invited to the meeting and registered managers were able to use this forum to share any good ideas or concerns related to their own service. The provider used training, meetings and emails to update services in relation to new initiatives, innovative practices or any updates that might be required. The provider recognised training was essential to improve staff skills, to ensure competence and confidence of workers in their support of those who live at the service. Staff were encouraged to reach their full potential and opportunities were given to develop their skills and abilities. Every year the provider held staff awards, to acknowledge and celebrate outstanding staff contributions both individually and team based.