

Homefield College Limited

Homefield View

Inspection report

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Ratings

Overall rating for this service

Requires improvement



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?

Requires improvement



Overall summary

This inspection took place on 5 October 2015 and was unannounced. At the last inspection on 5 September 2013 we asked the provider to take action to make improvements. We asked them to improve practice relating to obtaining people's consent and acting in accordance with it. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. We found that although the provider

had made some improvements where they had placed a restriction on a person support they had failed to act in accordance with the provisions of the Mental Capacity Act 2005.

Homefield View is a registered care service, providing accommodation, nursing and personal care for up to five people. There were five people using the service at the time of our inspection.

The service is required to have a registered manager in post. A registered manager is a person who has registered

Summary of findings

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. There was a registered manager in post at the time of our inspection.

People felt safe at the service. People took part in house meetings where they discussed health and safety. People were supported to attend an interactive learning session about health and safety.

People were supported with their medicines as prescribed. The service had identified they had surplus controlled drugs in stock but they had no action had been taken to rectify the situation.

People were given choices in day to day decision making. People told us that staff knew and understood their need. People's privacy was respected. Staff were caring, compassionate and kind. They listened and responded appropriately to people.

Staff went through a robust recruitment process and had an induction period once this had been completed. Staff received training, supervisions and appraisals within their roles.

People were involved in decisions about their care. Care and support plans were detailed and included specific details and guidance for staff to follow.

People had choices about the activities, outings and sessions that they attended. People were also able to make alternative choices and they were supported to do so.

Concerns and complaints that had been raised with the service had been investigated and acted upon. People felt able to raise any concerns they may have.

There was clear vision at the service shared by all of the staff. The values of the service included involvement, independence, dignity, respect, equality and empowerment. We saw the vision statement and mission statement on display within the service.

There were unannounced quality assurance audit visits carried out by the provider to ensure that the service was performing to a good standard.

Internal audits at the service had been carried out. Action had not always been taken by the service when a concern had been identified.

We identified a breach of the regulation where the service had failed to act in accordance with the provisions of the Mental Capacity Act 2005 where they had placed a restriction upon a person's care and support.

You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was safe.

People and their relatives felt they were safe at the service. People were supported to attend interactive learning sessions to aid their knowledge and understanding of health and safety situations. Incidents and accidents were investigated. There were surplus controlled drugs at the service that had not been reported appropriately.

Good



Is the service effective?

The service was not consistently effective.

The service was not following the relevant process were concerns around people's capacity had been identified. People were supported to eat a balanced diet. People had access to appropriate health professionals as required.

Requires improvement



Is the service caring?

The service was caring.

People were involved in decisions about their care. People's privacy was respected. Staff were caring, compassionate and kind. They listened and responded appropriately to people.

Good



Is the service responsive?

The service was responsive.

People received care and support that met their individual needs. People's views were listened to and acted upon. There was a complaints policy in place in a suitable format for people that used the service.

Good



Is the service well-led?

The service was not consistently well led.

Staff shared the same vision and values and promoted them through their daily work. Action had not always been taken by the service when an error had been identified.

Requires improvement



Homefield View

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 inspection took place on 5 October 2015 and was unannounced. The inspection was carried out by two inspectors.

We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law.

We spoke with four people that used the service and two of their relatives. We spoke with the registered manager, the daytime supervisor and two support workers. We spent time at the service observing support that was being provided. We looked at records relating to medication and carried out a stock check of four medicines that were used by people at the service. We looked at care records of the three people that used the service and other documentation about how the service was managed. This included policies and procedures, staff records and records associated with quality assurance processes.

Is the service safe?

Our findings

People told us that they felt safe at the service. One person told us how they, “Go to Warning Zone to learn about health and with staff.” [The Warning Zone provides people with an interactive health and safety learning experience.] Another person told us, “I feel safe.” A relative told us, “I feel [person’s name] is safe, I have no concerns about their safety.” Another relative told us, “[Person’s name] is safe.”

There were weekly house meetings held with people that used that the service where health and safety issues were discussed. These also provided people with the opportunity to discuss any concerns. One person described to us how they would evacuate the house in the event of a fire and identified the escape routes. We saw that fire drills were held regularly to ensure that people were familiar with the evacuation process should the event arise. We found that there were emergency grab sheets available that provided information about people’s needs. We saw that personal emergency evacuation plans were in place.

Staff had a good understanding of the various types of abuse and told us how they were able to report any concerns or incidents. They told us that they felt assured that any concerns they did report would be actioned but they were also aware of how to escalate their concerns should the need arise. Staff were provided with a safeguarding leaflet that they kept with their identification badges. Staff told us that this provided them with information and details about how to any suspected abuse should be reported and enabled them to have contact details to hand. There was a safeguarding team that had been established by the provider that met monthly to discuss and safeguarding concerns and review any actions that had been taken. This enabled the provider to ensure that they had a consistent approach and kept any safeguarding concerns under continual review.

We saw that incident and accident were investigated and forms were appropriately completed. These contained details about the event and prompted staff to review people’s risk assessments and care plans. They also

contained information about any actions senior staff had taken in response. Where incidents had been in relations to people’s behaviours we saw that there were detailed notes about de-escalation techniques used and the effectiveness of them. This information was then used to assess and review that risks were being managed appropriately.

People told us that there were enough staff at the service. Relatives told us they were happy with the staffing levels. The day time supervisor told us how the staffing at night time had recently changed due to people’s needs at the service. This meant that the service now had a waking night staff member on shift. Staff members told us that in the event of an unforeseen circumstance or to cover staff absence staff from other services owned by the provider were used to ensure that there were always sufficient staff on shift.

We looked at the staff files of three people that worked at the service. We found that the service followed a recruitment process and carried out pre-employment checks before people started work. This meant that they could be sure that staff were suitable for the roles before they started work.

One person told us, “I’m learning to administer my own medication, I like this.” We saw that there were policies and procedures in place for staff to follow to ensure that people’s medicines were managed safely. We saw that where possible people were encouraged to be involved in the administration of their own medicines. We looked at records relating to the administration of medicines that showed that people had received their medicines as prescribed and we saw that there were weekly stock checks done to ensure that stock levels were correct. However, we were concerned to find that there were 20 controlled drug patches that were not recorded in the controlled drugs register. This had been identified by the service two weeks prior to our visit but no action had been taken to rectify the situation. The provider should have reported this to the pharmacist and sought further guidance about this matter. All controlled drugs should also be recorded on the controlled drugs register.

Is the service effective?

Our findings

At the last inspection on 5 September 2013 we asked the provider to take action to make improvements. We asked them to improve practice relating to obtaining people's consent and acting in accordance with it. Following that inspection the provider sent us an action plan to tell us about the improvements they were going to make. We found that some improvements had been made. However, we were concerned that service was not following the process where concerns around people's capacity had been identified and over half the staff had still not received adequate training to enable them to understand the Mental Capacity Act 2005 and its requirements.

We saw that people were given choices in day to day decision making. One person was being asked what they would like to do next whilst other people were consulted about meal choices and hobbies and interests. Decisions about support and the gaining of consent for this were in some people's person-centred plans. Person-centred plans are documents about a person that are presented in a way that is understood by the person, wherever possible. One person-centred plan had the statement, "I would like this support plan to be read and for people to help me the way I want to be helped." Another plan viewed was not signed by the person or their representative to demonstrate their consent with it. Records did not consistently show that people's consent to care and support or their ability to understand or make decisions had been properly addressed in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation that protects people who lack mental capacity to make decisions about their care and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority and any decisions made in a person's best interests if they are not able to do this for themselves.

Some people at the service lacked capacity to make some decisions relating to their care. One person's care plan showed that they were under continuous supervision. There was no mental capacity assessment to consider their safety or supervision and no decisions or details of any best interest meeting. There had been no consideration as to whether this was a restriction of their liberty and no application to the local authority had been made. Where it

seems likely that a person is being deprived of their liberty, and this seems to be in the person's best interests, a referral to the Local Authority deprivation of liberty safeguards team should be made by the provider. No DoLS application had been made and so there was no authorisation for the continuous supervision to be in place. One part of the person's care plan referred to the best interests of the person but not in relation to the MCA.

We found in another person's care plan their capacity had been assessed relating to a specific decision but it was not clear how the best interest decision had been made or who had contributed to it such as family members or health and social care professionals. Where people did not have the capacity to consent, the service had not acted in accordance with legal requirements.

We spoke with staff about the MCA and DoLS. The manager understood their responsibilities in relation to the legislation but had not made sure that all required documentation was in place. Support staff did not have a clear understanding of the legislation or about their responsibilities and many had not received training in this area. This meant that people's consent to care and treatment was not always gained and people were at risk of their liberty being deprived without the required legal safeguarding of their rights.

These matters concerning consent and not acting in accordance with the Mental Capacity Act 2005 were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11 Need for consent.

People told us the staff team knew what support they needed. One person told us, "I have got staff that help me, they are really nice." Observations of staff showed they had the necessary skills and knowledge to support people at the service. Staff spent time when speaking to people and listened carefully to their response. We saw that staff provided people with information about what was happening now and what was going to happen next. This approach was consistent to people's plans of care and meant people's assessed needs were being met.

Records showed that an induction for staff period took place over a six week period. Inductions covered areas such as health and safety, safeguarding and confidentiality. Staff received supervisions and appraisals as documented in staff files. Supervision is a process where staff members

Is the service effective?

meet with their manager to discuss how they are performing and if there are any training needs or concerns. Staff told us they received regular training and supervision. This meant that people were supported by staff with the right skills. One member of staff had raised an issue in relation to lack of support. This had been raised internally and the person was now receiving the support they required. Staff generally felt supported by the management.

We observed people getting their own lunch which was pre-prepared and stored in the fridge. This happened at different times and people came and went into the dining area as they wished. Staff members were interacting with people throughout lunchtime. It was a relaxed and sociable time that we observed that people enjoyed as they had smiles on their faces. Where necessary, people were offered support to access and eat their lunch at a level and pace that suited them. A care plan for one person highlighted the need to record what the person has eaten as there is a risk the person may not get enough food and drink. Staff confirmed they did this and this was seen in the person's communication book. Food likes and dislikes were identified in people's person-centred plans and care plans.

People told us they get the food they like and they are involved in the preparation, cooking and serving of food. One person told us, "They support me and help me with meal planning; we have books that we can choose from." Menu-planning occurs every week with people who use the service. This was occurring on the day of the inspection and people were given advice on healthy options. People were supported well with nutrition; staff knew the needs of people they support and independence was actively encouraged.

People had access to health professionals and specialists. We saw that a referral had been made to a community nurse for advocacy work. We saw that a referral had been to the in-house therapy and education team following an incident. These were made without a delay. Staff told us that people had or needed any health professional appointments then these would be discussed at the handover. Relatives told us that they felt people were supported appropriately with health professional appointments. People were encouraged to use symbols and pictures to describe how they are feeling and to ascertain if people required any medical support.

Is the service caring?

Our findings

People told us that staff were caring. One person told us, “I’ve have got staff that help me, they are really nice.” Another person told us, “They care.” Relatives told us that staff got to know and understand people well. They told us that their relatives were very happy living at Homefield View and staff had helped them to settle in.

We saw that staff spoke to people with kindness and compassion. They offered reassurance when required to support people but did not take over the tasks that people were doing. For example, after lunch people were gently reminded and talked through the process of washing and tidying up. People understood what staff were telling them and were guided by their instructions.

Where people had the capacity to be involved in decisions about their care and support they were. They were involved in the assessments of their needs and provided information about how they wanted to be supported. They were provided with a timetable of sessions and activities and were able to choose which ones they participated in. People did this through a meeting with their keyworker.

People at the service had a keyworker who was responsible for ongoing communication with relatives and for ensuring that people were happy with the care, support and activity plans that were in place. A relative of a person at the service told us how their keyworker had changed as they did not appear to bond with their original keyworker. They went on to tell us that this had been identified and changed by the service. They also told us that their relative now had a good relationship with their keyworker as they were more suited to their needs and had similar interests.

Staff told us that relatives and friends of people using the service were able to visit them without undue restriction. Relatives that we spoke with confirmed that this was the case.

We saw that staff used communication methods identified in people’s care plans to engage with them. The staff team altered their communication style where needed and were responsive to requests for support. The staff’s approach was encouraging to enable people to carry out tasks for themselves.

A member of staff showed us a range of pictures, symbols and photographs that can be used to support communication with people. These were seen in practice during a menu planning activity that people were undertaking with staff. The communication methods deployed by staff were effective in meeting people’s needs. One person told us, “They [the staff] support me and help me with meal planning, we have books that we can choose from.”

People told us that they had keys to their rooms. This enabled them to have the privacy that they required. Staff respected people’s privacy. People told us that staff knocked and waited for a response before they went into people’s rooms. We saw that staff knocked and waited in line with this procedure. Staff told us that they did not go into people’s rooms with their authorisation.

People using the service had their bedrooms decorated to their taste. One person showed us how they had chosen to decorate and furnish their room. People’s rooms were personalised and were places where people could spend time alone if they wanted.

Is the service responsive?

Our findings

People we spoke with told us they were involved in making decisions about their care. Relatives told us that they were involved as much as they wanted and needed to be in decisions relating to people's care. A relative told us, "There has to be a balance, [person using the service] needs their independence too," they went on to tell us, "We're just so pleased with the progress that [person using service] has made." People told us that they were able to make choices about the things that they did. We observed staff providing people with choices and enabling people the time they needed to respond.

We saw that people's support plans provided details of their likes, dislikes and preferences. We saw that pictorial aids had been used throughout support plans to assist people to understand. Care and support plans were detailed and included specific details and guidance for staff to follow. However it was not always evident when these had last been reviewed regularly.

We saw that people had annual reviews that included relatives and all of the people involved in their care. People were supported by their keyworkers to produce a report for their review that included information about things they had done and achieved in the past year and their aspirations for the year ahead. It also enabled them to analyse the year and think about what had gone well for them and what had not gone so well.

People told us they were able to choose the activities that they wished to participate in. We saw that there was a variety of activities that took place and people were able to choose the ones that they participated in. Relatives told us that on the whole the activities available met their relative's needs. A relative told us, "If [the person using the service] don't like the activities they are doing then they'll change

them." Another relative told us that they [the person using the service] did not enjoy the activity that was available on a Wednesday night so they had asked to do something else instead. They told us that staff supported them to do this and this was what they were now doing.

A relative told us that following a family bereavement the service provided drama therapy for their relative to help them to deal with the situation and express their feelings in relation to it. They told us how the service had sourced this and liaised with the family to ensure that it was agreeable. They went on to tell us how this had been of great benefit to their relative.

Relatives told us that if they had ever had to raise anything with the service they felt able to and they felt assured that it would be addressed. One relative told us how they had reported a concern about a particular area of care and the service took action. They went on to tell us how the service had carried out their own research and ensured that staff had all of the relevant details, knowledge and guidance to ensure that the issue did not arise again. They were satisfied with the outcome of this.

We saw that complaints and areas for improvement were discussed with people as part of house meetings that took place. People were asked if they were happy, wanted to talk about anything or had any suggestions.

We saw that the complaints policy was available for people in a pictorial format. People told us that if they had any concerns they would tell the staff. The complaints policy included information about the different stages of the process and provided timescales in which complaints would be investigated with in. We saw that where complaints had been made they had been investigated and responded to. We saw that the service had put measures in place to reduce the risk of the event happening again.

Is the service well-led?

Our findings

Relatives told us that they were able to talk to staff about anything and they could be assured that it would be addressed. Staff told us that they felt able to raise any issues that they may have. We evidence of a grievance that had been raised by staff and a staff member told us how they had raised something that they were not happy with. We saw that these people were supported through the process by the service. One person told us, “Regardless of everything else people [that use the service] are always put first.”

Staff spoke positively about the service and the leadership of it, one staff member told us, “People are all treated as individuals.” Another staff member told us, “I feel well supported.”

There was clear vision at the service shared by all of the staff. The values of the service included involvement, independence, dignity, respect, equality and empowerment. We saw the ‘vision statement and mission statement’ on display within the service. Staff had a detailed knowledge of the services vision and values. These were promoted by staff. We saw that the registered manager also promoted these values through their daily work. They spent time at the service to enable them to monitor that staff were displaying these values through their daily work.

The registered manager at Homefield View had only been the registered manager of the service for one month. They had however managed the service for approximately four months prior to our inspection. The statement of purpose for the service was clear but required updating to refer to the current registered manager of the service. The registered manager was aware of the requirements of their role. We had received notifications as required from the service.

Staff told us that staff meetings had taken place. We saw minutes that demonstrated that these were used to share important information with staff and provide staff with the opportunity to discuss any concerns. These had not been held on a regular basis. We discussed this with the registered manager who told us that since the organisational changes and due to staff sickness these had not been held as frequently as they would have liked but they were working to improve on it. We saw that the communication processes between staff at the service on a day to day basis worked well.

There was an annual summer event held by the provider that relatives were invited to. Relatives confirmed that this was the case. Feedback about the service was positive.

We saw that unannounced quality assurance audit visits were carried out by the provider at least four times a year. A report was provided to the registered manager to which they had to provide a response and action plan to address the items that had been raised. We saw that areas of improvement that were required were followed up at the next quality assurance visit. There was a robust system in place to ensure that concerns that were identified had been addressed.

The internal audit system at the service had identified that additional controlled drugs were in stock but the service had not taken any further action to rectify the situation. There was a risk that staff had access to controlled drugs at the service that were not recorded on the register. There was a risk that they could be taken and either given to people incorrectly or disposed of and there would be no audit trail in place. Audit systems had failed to identify that the required documentation in relation to a person’s capacity and restrictions upon their care were not in place.

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	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met: Where people lacked the capacity to consent to their care and treatment the provider had failed to act in accordance with the provisions of the MCA 2005. Regulation 11 (3).</p>

The enforcement action we took:

We have issued a Warning Notice which we have asked the provider to comply with by 25 November 2015.