Abbeyfield Society (The)

Victoria House

Inspection report

2-4 Ennerdale Road
Kew
Richmond
Surrey
TW9 3PG

Tel: 02089400400
Website: www.abbeyfield.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 27 and 28 November and 1 December 2017.

Victoria House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Victoria House accommodates 30 older people in one adapted building.

The home had a registered manager. 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 and associated Regulations about how the service is run.

At the last inspection in December 2015 all the key questions of safe, effective, caring, responsive and well-led were rated good and there was an overall rating of good. At this inspection we have made a judgement of requires improvement for the well led question. This failing represents a breach of the Health and Social Care (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives said the care and support provided at Victoria House was very good and they liked its friendly atmosphere. There were enough staff available to meet people's needs and the staff were friendly, helpful and attentive providing care and support in a kind and skilful manner.

Most of the home's records were comprehensive, kept up to date and regularly reviewed with information recorded in a clear and easy to understand way. However the quality assurance system had not picked up some review information that had not been updated on a sample of people's records. We have made a requirement in respect of this.

People and their relatives were encouraged to discuss health needs with staff and had access to community based health professionals when required. They were protected from nutrition and hydration associated risks by balanced diets that also met their likes, dislikes and preferences. People and their relatives said the quality of the meals provided and available choices was good. People were prompted to eat their meals and drink at their own pace.

Victoria House was well maintained, furnished, clean and provided a safe environment for people to live and staff to work in.

Staff were competent and knowledgeable about the people they cared for. They had appropriate skills and training and were focussed on providing people with individualised care and support. This was provided in a professional, friendly and supportive manner. They were aware of their responsibilities to treat people

equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences. Staff said the registered manager and organisation provided good support and there were opportunities for career advancement.

People and their relatives thought the registered manager and staff were approachable, responsive, encouraged feedback from people and consistently monitored and assessed the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

'The service remains Good.'

Is the service effective?

Good

'The service remains Good.'

Is the service caring?

Good

'The service remains Good.'

Is the service responsive?

Good

'The service remains Good.'

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

The quality assurance system did not pick up all areas where recording and monitoring was required.

There was a clear vision and positive culture within the home that was focussed on people as individuals. They were enabled to make decisions in an encouraging and inclusive atmosphere. People were familiar with who the registered manager and staff were and encouraged to put their views forward.

Staff were well supported by the registered manager and management team and advancement opportunities were available.

Victoria House

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 was an unannounced inspection and took place on 27 and 28 November and 1 December 2017.

This inspection was carried out by one inspector over three days.

There were 27 people living at the home. We spoke with 11 people, ten relatives, seven staff, the registered manager and two healthcare professionals whom had knowledge of the home.

Before the 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 also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for three people and three staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People said they felt safe living at Victoria House and their relatives told us they felt safe leaving people in the care of the staff and registered manager. They thought the home had a relaxed atmosphere and that there were enough staff who provided care in a way that made people feel safe. One person told us, "Oh yes, I feel safe." Another person said, "It's home and I enjoy living here." A further person commented, "I feel safe and happy with the environment." A relative told us, "I feel confident here, in contrast to other homes. It means I am confident in going away"

During the inspection sufficient staff were on duty to meet people's needs and matched the numbers recorded on the staff rota. The registered manager said that the staff rota was flexible to meet people's needs and extra staffing was supplied when needed. Relief staff cover was provided from within the home and organisation where possible. This meant people's needs were met in a safe, unrushed and enjoyable way. This was reflected in their positive body language and responses to staff, particularly people who had limited verbal communication. There were staff recruitment interviews taking place in the week of the inspection.

Staff had been trained in safeguarding, were aware of how to raise a safeguarding alert and when they should do so. The staff handbook contained safeguarding information and a safeguarding pathway with local authority contact numbers was available to staff. There were no current safeguarding alerts. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from.

The home had policies and procedures regarding protecting people from abuse and harm. Staff were trained in them and followed them during our visit. We asked staff to explain their understanding of what abuse was and the action they would take if they encountered it. Their responses followed the provider's policies and procedures. Staff told us that protecting people from harm and abuse was included in their induction and refresher training and one of the most crucial parts of their job.

People's care plans contained risk assessments that enabled them to enjoy their lives safely. The assessments identified areas of risk relevant to people as individuals including their health, daily living and social activities. The risk assessments were reviewed and updated when people's needs and interests changed. Staff shared relevant information, including any risks to people during shift handovers, staff meetings and when they occurred. They were also used as opportunities for discussion if something had gone wrong so lessons could be learnt. The home also kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and knew how to use.

There were building and equipment risk assessments that were reviewed and regularly updated. The home's equipment was regularly checked and serviced. This included a fire evacuation plan. Staff had received infection control training and their working practices reflected this. There was also a good stock of gloves and aprons for giving personal care.

The home's staff recruitment process was thorough and records demonstrated that it was followed. The

process included scenario based interview questions to identify prospective staff's skills and knowledge of their duties and responsibilities. References were taken up and Disclosure and Barring service (DBS) security checks carried out, prior to starting in post. DBS is a criminal record check employers undertake to make safer recruitment decisions. There was also a three monthly probationary period with monthly review meetings. If there were gaps in the knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed. Staff work history and right to be employed were also checked.

Staff had received training in de-escalation techniques where people may display behaviour that others could interpret as challenging. This was put into practice with staff using different techniques specific to people individually that were recorded in their care plans.

Medicine was safely administered, regularly audited, appropriately stored and disposed of, when required. We checked people's medicine records and found that they were fully completed and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specific controlled drugs. Staff were trained to administer medicine and this training was regularly updated. Medicine kept by the home was regularly monitored at each shift handover and audited monthly. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

People were enabled to be and involved in decisions about their care and support and their relatives also had input. Staff communication skills showed us that people were able to understand them and this enabled staff to meet people's needs well. They spoke to people in an unhurried way so that people could understand what they were saying. Staff made eye level contact and used appropriate body language that people responded to. This was enhanced by the home's comfortable, relaxed atmosphere that people said they enjoyed. People and their relatives told us the way staff provided care and support was what they needed and was delivered in a friendly, patient and appropriate way. One person said, "A home, not just a care home." Another person told us, "It's great, you can do what you want. The only improvement I would make is a ski ramp out the back. Only kidding." A relative said, "I cannot speak highly enough of this place." Another relative told us, "This place has it pretty well sorted."

Staff received induction and annual mandatory training and a staff handbook. The induction included core training and information about staff roles and responsibilities. It also outlined the home's expectations of staff and the support they could expect to receive. All aspects of the service and people were covered. New staff shadowed more experienced staff to gain knowledge about how the home ran and people living there. There was a training matrix that identified when mandatory training was due. Training encompassed the 'Care Certificate Common Standards' and included infection control, manual handling, fire safety, emergency aid awareness, food hygiene, equality, diversity and human rights and health and safety. There was access to specialist service and person specific training including dementia care and foot care.

The home was involved in a pilot scheme called the Namaste Care Programme that staff had received training in. The programme was focussed on enhancing the quality of life of people with advanced dementia through daily engagement in physical, sensory and emotional care practices by engagement with staff, relatives and people's surroundings. Two staff were also undertaking a six month dementia coach's course provided by Worcester University. The organisation had facilitated a learning and development academy which had a lending library that provided books that backed up the training provided. Group training needs were also identified during monthly staff meetings. Bi-monthly supervision sessions and annual appraisals were also partly used to identify any gaps in individual training. There were staff training and development plans in place.

Staff also received equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected in the staff care practices and confirmed by people and their relatives. People were treated equally and as equals with staff not talking down to them. One relative told us, "The manager is great, doesn't sit behind a desk and recognises everyone. She knows my mum and other people."

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support as required. Records demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams and district nurses, making referrals when required and sharing information. The registered manager also

attended local authority hosted provider forums where information was shared.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under the DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit.

There was a section in people's care plans for health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. If required weight charts were kept and staff monitored how much people had to eat. There was also person specific information regarding any support required at meal times. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. Nutritional advice and guidance was provided by staff and there were regular visits by a local authority health team dietician and other health care professionals in the community, such as district nurses. People had annual health checks. Records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

People chose the meals they wanted and there was a good variety of choice available. The meals were of good quality and special diets on health, religious, cultural or other grounds were provided. The meals we saw were well presented, nutritious and hot. They were monitored to ensure they were provided at the correct temperature. Staff care practices showed that people's needs were met in a timely way and no one was kept waiting for their lunch. People said they enjoyed the meals. One person said, "Great food." Another person told us, "Enough variety."

During lunch staff met the needs of people with dementia in a patient, inclusive and encouraging way. People had meal choices explained and staff revisited this as many times as people required to help them understand, re-assure them and make them comfortable. They also spent time explaining to people what they were eating and checking they had enough to eat.

The home was clean and well-maintained and there were no unpleasant odours. The layout was conducive to providing people with a homely atmosphere with suitable communal and personal accommodation. Work was taking place to install a 'Breath of fresh air' dementia garden within three areas of the grounds

that had won an award at the Hampton Court Flower show.

Good

Is the service caring?

Our findings

People and their relatives said the home provided a service based on treating them with dignity, compassion and respect. Staff were attentive and responded to people promptly. They addressed people by their preferred name or title and knocked on bedroom doors and awaited a response before entering people's rooms. People said staff listened to them, acknowledged and valued their opinions and delivered care in a friendly, patient and helpful way. One person said, "The staff are excellent, kindness itself." Another person told us, "A bunch of really special people." A further person commented, "Easy going, friendly people." A relative said, "Staff do their jobs very well." Another relative told us "So gentle with the residents, I can relax."

Staff made a real effort to ensure people's needs were met and this was reflected in their care practices. They stimulated people prompting conversations with them and other people whilst performing their duties in a patient and skilled way. They applied their knowledge of people and their needs and preferences well to promote people to lead happy and rewarding lives. This was individually and as a team. People were treated with kindness and understanding with staff taking an interest in them. This approach was supported and underpinned by the life history information contained in care plans that people, their relatives and staff contributed to and regularly updated.

There was an advocacy service available through the local authority. Currently people did not require this service.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People and their relatives confirmed that their views and opinions were sought formally and informally by staff and the registered manager and organisation. Staff encouraged people to make their own decisions and took action on them. They made themselves available to people and their relatives if they wished to discuss any problems or if they just wanted a chat. One person said, "You can have a laugh and a joke with staff which is very important. Otherwise I would be very morose." Another person told us, "Staff are very approachable and if you have a problem, they will fix it." A relative said, "They [Staff] are always around if you need them."

People and their relatives were provided with pre-admission written information about the home. This included the type of care and support they could expect. They were invited to visit as many times as they wished before deciding if they wanted to move in and fully consulted and involved in the decision-making process. Staff explained how important it was to capture people's views as well as those of relatives so that care could be focussed on the person.

People were referred privately and by local authorities. Assessment information was provided by local authorities and any available information sought for the private placements where available, from previous placements, GP and hospitals. The registered manager shared this information with appropriate staff to identify if people's needs could initially be met. The home carried out a pre-admission needs assessments with the person and their relatives. People were invited to visit the home before deciding if they wished to move in. These visits were also used to identify if they would fit in with people already living at the home. There was a review of the placement after six weeks.

The home's pre-admission assessment formed the initial basis for people's care plans. The care plans were focussed on people as individuals. They were live documents and contained social and life history and interests that were added to by people and staff when new information became available. The information gave people and staff the opportunity to identify activities they may wish to do. People and staff confirmed that needs were regularly reviewed and re-assessed. People agreed goals with their lead staff that were also reviewed and daily notes fed into the care plans. However the sample of care plans we looked at had not been updated to reflect this. The daily notes confirmed that identified activities had taken place. People were encouraged to take ownership of their care plans and contribute to them as much or as little as they wished. Care plan goals were underpinned by assessments of risk to people.

The home provided a variety of activities based people's suggestions and staff and volunteer knowledge of people's likes and dislikes. The success of this approach was reflected by the high participation of people in the activities. One person said, "I join in if I want to." Throughout our visit people were consulted, by staff about what they wanted to do and when. We saw this during activity sessions where people were encouraged but not pressurised to join in. People were also encouraged to interact with each other rather than just staff. In this context we conducted an interview with a group of six people as they elected to use this format rather than individual interviews, after consultation with staff and each other.

There was a timetable of activities available to people that took into account their interests and participation abilities with staff reminding them of what was taking place that day. The Namaste programme provided visual, music, aroma and visual stimulation in tandem with therapeutic touch and personalised, individual communication nurturing for people with advanced dementia. The activities co-ordinator facilitated other activities that people had chosen. These included a bingo session and reading club that took place during our visit. There was also an open coffee morning arranged with local residents scheduled for the Saturday following the inspection.

There were daily activities provided that included exercise, quizzes, scrabble, cinema club, reminiscence sessions, visiting shop and arts and crafts. There was also a visiting hairdresser. Every week there was a down tools session were all staff spent time with people. One person said, "More than enough to do." Another person told us, "The activities person is really, really good." A relative said, "I enjoy coming here and talking to staff as well as visiting [Person]." Other relatives told us they thought the activities provided were appropriate and that people enjoyed them.

The home provided end of life care, staff had received appropriate training from organisations such as the Princess Alice Hospice, and there was specific reference to end of life in people's care plans including guidance and people's wishes. When providing end of life care, the home facilitated relatives to be involved in the care as much or as little as they wished during a distressing and sensitive period for them. The home liaised with the appropriate community based health teams and organisations such as the Community Matron, palliative care teams and MacMillan nurses.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew their duty to enable people to make complaints or raise concerns.

Relatives were invited and encouraged to attend regular meetings to get their opinions. One relative told us, "I attend regularly and we have a strong relatives group." The meetings were minuted and people were supported to put their views forward including complaints or concerns. The information was monitored and compared with that previously available to identify that any required changes were made.

Requires Improvement

Is the service well-led?

Our findings

On the sample of the three care plans we checked, the records of monthly reviews had not been updated. The registered manager explained that the team leaders with responsibility for ensuring these records were up to date were relatively new in post and still coming to grips with the quality assurance systems. The people and staff we spoke with said the reviews had taken place, although they were not recorded. The quality assurance system had not picked up that care reviews on the samples of care plans we looked at had not been updated.

This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality assurance system had monitored other areas of the running of the home such as health and safety, food hygiene, fire safety, training and medicine administration.

People and their relatives were actively encouraged to make suggestions about the home and any improvements to the service it provided. Relatives said the registered manager operated an open door policy. This made them feel comfortable to approach the registered manager as well as the staff. One person told us, "The manager is so in the right job." Another person said, "A well organised group [Staff] which indicates well managed." A further person commented, "I used to worry all the time, now I don't worry at all." One relative told us, "The manager has brought the staff on by giving them responsibility."

The organisation had a clear vision and set of values that staff understood and embraced. They said that the vision and values were explained to them during induction training and regularly revisited at staff meetings. The management and staff practices we saw reflected the vision and values as they went about their duties. There was a people's charter that described what people could expect from the organisation, Victoria House, its staff and the home's expectations of them.

Victoria House made great efforts to engage with the local community and also had a very active 'Friends of Victoria House' group that incorporated relatives and met quarterly. During Christmas the home will be participating in the organisation's 'Companionship at Christmas' scheme inviting older people in the community with no one to spend Christmas with to join them. People from the assisted living service opposite, that is also part of the organisation were also invited to Christmas lunch.

The home and organisation had clear lines of communication and staff were made aware of areas of responsibility specific to them. There was a whistle-blowing procedure that staff said they were comfortable using. The organisation HR manager also held surgeries for staff on a monthly basis to provide guidance and support.

The Registered Manager was a member of the internal 'Embrace' national panel that supported and developed the organisation's dementia strategy and also attended the Richmond Community Care Forum that was facilitated by the local authority. They were also a bereavement and cancer councillor. Staff said

the registered manager and management team provided very good support for them. They thought that service improvement suggestions they made were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member told us, "I enjoy it; the manager is lovely and helpful." Another member of staff told us, "The training is really good, I love working here it's like my family."

Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There were audits, senior business managers' and finance officer monthly visits, pharmacy reviews, weekly and monthly health and safety checks and operational business plans. There were also monthly critical friend visits from other managers within the organisation to quality assure the service in a cycle, annual policy and procedure reviews and visits from the local authority commissioning and quality teams. A critical friend was someone who provided constructive criticism.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance system did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (a)