# Central & Cecil Housing Trust

# Homemead

## Inspection report

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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? | Good |

## Overall summary

We carried out an inspection of Homemead care home on 6 July and 7 July 2015. The inspection was unannounced. At the previous inspection of 27 May 2014 the home had met all the standards.

Homemead is a home for up to 26 older people, including people living with dementia. At the time of the inspection there were 20 people living in the home. The home has 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 2008 and associated Regulations about how the service is run.

People who lived at the home were protected from the risk of abuse happening to them. People who were able to express their views told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or

# Summary of findings

wellbeing. We saw that other people, although unable to express their opinions, were able to move freely around the home, speak with staff and receive support that made them feel reassured and safe.

Risk management plans were in place for people and clearly identified areas that presented possible risk to safety and wellbeing. There was guidance for staff on how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

People had an individual care plan which set out their care needs. We saw that people and their relatives had been involved in the assessment of their health and care needs and had contributed to developing their care plan. Assessments included needs for any equipment, mobility aids and specialist dietary requirements. People had access to a range of health care professionals some of which visited the home. This meant that people were sure that their individual care needs and wishes were known and planned for and that they had the equipment they needed to meet their individual needs.

There were enough staff on duty to care for people, with between four and five care staff with support from senior care staff and manager. Staff had been trained to use specialised equipment, such as hoists, safely.

People and relatives told us that they were happy with the care they received and felt their needs had been met. Care staff understood people's care and support needs and knew people well.

The provider had a Service User Guide which emphasised the rights of people to be treated with dignity, to have privacy and to be able to exercise choice. This was also reflected in the home's policies and procedures and formed the basis for staff training.

The provider ensured that people's independence and choice was promoted, for example through meetings and communication with relatives. People told us that they had been involved in making decisions and there was good communication between staff and themselves.

We saw that people's health, nutrition, fluids and weight were regularly monitored. The chef was closely involved in ensuring that people's choices about meals were taken into consideration and there were well established links with GP services and pharmacist services offering a single point of access for people.

People told us that the staff were kind and caring towards them.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences. Care records included details such as personal achievements, places visited and family relationships.

We listened to how staff spoke with people and found this was professional and relaxed, and included friendly chit-chat between staff and people who used the service. We saw how people who used the service responded positively to the interaction. Staff responded promptly when asked a question and took time to explain their actions.

People said they were able to get up and go to bed at a time that suits them and were able to enjoy activities and interests that suited them. The home also supported people to maintain relationships with family, relatives and friends.

The home's philosophy placed importance on ensuring that people who live at the home continued to lead as normal a life as they were able. The activity team leader and staff spent time getting to know the individual, their background and life history.

In order to listen to and learn from people's experiences the home had developed an approach that asked people about their life histories and also held three-monthly meetings with relatives. Relatives we spoke with told us that they found these meetings helpful.

The provider had an effective system to regularly assess and monitor the quality of service that people received. This was done through regular audits as well as regular visits by the Area Manager. Relatives were complimentary about the accessibility of the manager and the atmosphere in the home.

A copy of the complaint's procedure was displayed near the main entrance. No complaints had been made to CQC or the local authority during the last year.

# Summary of findings

The manager and staff maintained a focus on keeping up to date with best practice through participation with groups such as the local authority provider forum and dementia care organisations.

# 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?**

Good

The service was safe. People who lived at the home were protected from the risk of abuse happening to them. There were clear policies and procedures in place relating to safeguarding and whistleblowing.

Staffing levels were appropriate to meet the needs of people who used the service.

Medicines, including controlled medicines were safely and securely stored in a locked medication cupboard.

**Is the service effective?**

Good

The service was effective.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

Staff received appropriate training and supervision and understood the relevant requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were registered with a GP and had access to other health and social care professionals

**Is the service caring?**

Good

The service was caring.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences.

People's needs in respect of their age, disability, gender, race, religion and belief were understood by the staff and met in a caring way.

**Is the service responsive?**

Good

The service was responsive.

People's requests for assistance throughout the day were responded to promptly and people told us they never had to wait too long for assistance.

The activities officer had a full programme of activities for people which were prominently advertised and displayed.

The home had a complaints procedure that was understood by people. People told us felt confident that any problems or complaints that might arise would be dealt with by the management in a satisfactory way.

**Is the service well-led?**

Good

The service was well-led.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

# Summary of findings

People were very positive about the culture and atmosphere in the home.

The manager and staff maintained a focus on keeping up to date with best practice through participation with groups such as the local authority provider forum and dementia care organisations.

# Homemead

**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 6 July 2015 and 7 July 2015 and was unannounced.

The inspection team was made up of one inspector. Before the inspection we looked at information about the home that we had. This included previous inspection reports, correspondence and notifications.

During the inspection we spoke with four people living in the home and two relatives. We also spoke with nine members of staff, including two senior care staff, two care staff, deputy manager, chef, two area managers and the home administrator.

We looked at the homes policies and procedures, three care records, four medicines administration records and four staff records.

We observed the care practice at the home, tracked the care provided to people by reviewing their records and interviewing staff.

Good

# Is the service safe?

## Our findings

People who lived at the home were protected from the risk of abuse happening to them. People who were able to express a view told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Comments included, “It’s allright here. You can talk to people if you are worried.” Another person told us, "Yes I feel quite safe here, no one does you any harm.”

One relative we spoke with told us, “There are no concerns at all on that front. [name of person] is in good hands here.”

This indicated that people who used the service and their relatives had confidence staff would keep them safe from harm.

Staff were supported with information to guide them in the event of a safeguarding concern being identified. The home had clear procedures and policies regarding safeguarding adults and followed the Pan-London safeguarding procedures.

Staff were knowledgeable about the different types of abuse and the signs which indicate abuse may have occurred. Staff described the reporting process they would follow if they witnessed, suspected or had been told an incident of abuse had taken place. This was in line with the home’s safeguarding procedures.

We looked at examples of safeguarding alerts that had been raised with the local authority and with the Care Quality Commission (CQC) and saw that these had been actioned in line with stated procedures.

All of the incidents except one relating to safeguarding were incidents that had occurred between people living in the home and were clearly a result of behaviour related to dementia. Although the home had practices and procedures in place to resolve such issues, we saw that they complied with local authority requests to process these as safeguarding issues. One instance of safeguarding related to an occurrence of a medication administration error. This had been promptly reported, an investigation had taken place and an action plan had been developed which included further training for a member of staff and resolved satisfactorily.

Staff told us they had completed up to date training in safeguarding and records confirmed that staff had attended safeguarding training in the last 12 months and that refresher training was planned on an annual basis.

Risks to people’s health, safety and welfare had been assessed and where appropriate a risk management plan had been put in place for aspects of people’s care and support. Risk management plans covered aspects of care such as, nutrition, mobility, physical and emotional health and medication and they formed part of the person’s care plan.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible. For example, care records and risk assessments highlighted risks regarding mobility, behaviour and health needs. Records showed that risks people faced were reviewed and updated on an ongoing basis.

People were free to move safely from one from one area of the home to another including an outdoor secure garden. There were combination locks on some doors to private areas of the home and to the main entrance.

Visitors to the home signed a visitors book and identified themselves clearly to staff, which meant that staff were aware of who was in the home at all times and in what capacity.

The provider had a staff recruitment and selection policy and procedure. Recruitment procedures ensured that people were protected from having unsuitable staff working at the service. We viewed a sample of four staff records and found that information and checks required by law for recruiting new staff were obtained. The recruitment process included details of previous employment, checks made under the Disclosure and Barring Scheme (DBS) and reference checks. Staff confirmed that they had completed an application form, attended interview and underwent appropriate checks prior to starting work. This ensured staff were fit and suitable to work in a care setting. Staff underwent an induction and probationary period during which time they became familiar with people and the home’s policies and procedures.

There were enough staff on duty to care for people, with between four and five care staff with support from senior

Good

# Is the service safe?

care staff and manager. Staff had been trained to use specialised equipment, such as hoists, safely. At night there were two senior care staff and one care assistant on waking duty.

Medicines, including controlled medicines were safely and securely stored in a locked medication cupboard. The medicines cabinet was locked and could only be accessed by a key which was held by the senior staff member on duty. There was a system in place for ordering and delivery of medicines in blister packs on a four weekly basis by the local pharmacy. Medicines were disposed of safely with a system in place for counting, returning to the pharmacy and signing where medication needed to be disposed of. We saw that medicines which needed to be stored in a fridge were appropriately stored with the temperature being regularly monitored and checked.

The care staff responsible for administering medicines at the time of inspection was able to speak confidently and knowledgeably about the procedures and showed a good understanding of the types of medicines and what they were for.

We checked a sample of four people's medicines administration records (MARs) and saw they included details of allergies, prescribed medicines and instructions for administration. MARs also recorded when medicines were administered or refused and this gave a clear audit trail and enabled the service to monitor medicines kept on the premises.

The premises were free from hazards. The building and equipment used at the service was maintained to a safe standard. Records showed that regular checks had been carried out by an approved person, on equipment and systems such as the passenger lift, fire alarms, electrical appliances and lifting equipment.

Staff had been trained to use specialised equipment, such as hoists, safely. This helped people and staff to feel reassured when using such equipment.

There were procedures and policies in place to control infection. We looked around the service and saw that all areas were clean and hygienic. Staff had received infection control training and records confirmed this.

There was a good supply of personal protective equipment such as aprons and disposable gloves to minimise risks of the spread of infection. There were hand washing facilities including liquid soap and paper towels which enabled people who used the service, visitors and staff to maintain hand hygiene and reduce the risks of cross infection. We noted that there were anti-bacterial cleansers located throughout the home with notices requesting people to use it.

The laundry was appropriate to the needs of the people who used the service. Clean and soiled laundry was stored separately to minimise the risks of cross infection.

Good

# Is the service effective?

## Our findings

People told us that they were happy with the care they received and felt their needs had been met. From our observations we saw that staff understood people's care and support needs and that they knew them well. One relative told us, "The staff know the residents and know how to approach each of them in their own way. They are very good."

One relative told us that they found the home more personable and friendly than other care homes they had looked at. "It's a world apart. Staff know what they are doing and they care. The manager is also really helpful and is always available if you need her."

The provider ensured that people's independence and choice was promoted. For example, the home was set out in order that people could decide where they wanted to be, whether that was to walk around the home or to take part in an activity in another room, or to remain in their own room.

Staff told us they received sufficient training and felt very supported by the manager. Some staff had worked at the home for several years and knew the people well. Training records showed staff were appropriately skilled and experienced to care for people safely. In addition to safeguarding training, training also included first aid, moving and handling, fire safety and dementia care.

Care staff received regular supervision and annual appraisals. One senior staff member told us that she carried out monthly supervision sessions which included staff personal agendas, training, weakness and strength. We looked at a sample of four staff records and saw that supervision and appraisals had taken place in the previous 12 months.

At the time of inspection we saw that work had begun on a project that was discussed at the previous inspection. This was to change the elevator so that it could accommodate more people at one time and also make transferring people who were ill from their rooms to the ground floor easier and more dignified for the person.

We saw that the provider and manager had developed sound links with the local social and health services, provider forums and other organisations which could help them keep up to date with best practice.

Relatives we spoke with told us that they had been involved in making decisions and there was good communication between staff and themselves. They also confirmed that their consent was asked for before doing anything in people's best interests, such as going somewhere, or receiving medicines.

The deputy manager and staff confirmed that they had an understanding of the Mental Capacity Act. The Mental Capacity Act (MCA) 2005 sets out what must be done to ensure the human rights of people who lack capacity to make decisions are protected. Staff told us that they were aware of their responsibilities on a day to day basis when working with people who use the service to help them understand their care and treatment including gaining their consent. Records showed that MCA training was being delivered on a rolling basis to care staff.

Records confirmed that people's capacity to make decisions was assessed before they moved into the home and on a daily basis thereafter. We saw how the home made requests for authorisation to restrict people's liberty in their best interests under the Deprivation of Liberty Safeguards (DoLS). DoLS requires providers to submit applications to a "Supervisory Body" if they consider a person should be deprived of their liberty in order to get the care and treatment they need. At the time of inspection 20 applications had been made to the supervisory body, which was the London Borough of Richmond social services and the home maintained an up to date of those applications and progress made.

Staff were knowledgeable about people's dietary needs and preferences. People could choose to eat in the dining room, a lounge or eat in their room. The home used an external catering company to provide management and ownership of the catering arrangements in the home. However, the preparation and cooking of meals was carried out by a chef on the premises. The chef also took personal responsibility for checking people's opinion of the food and choice of menu which would be amdended to reflect those choices. There was a 5 day menu displayed on the activity notice board on each floor. The tables were laid with, napkins, cutlery and condiments.

During the hot weather staff told us how they were extra vigilant regarding people's fluid intake and we saw regular drinks being offered to people.

Good

# Is the service effective?

People spoke positively of the quality of the meals. One person told us, “The food here is lovely, and there is plenty of it.”

We saw that staff were knowledgeable about the needs of people who required support during mealtimes and were observed to provide this in a way that helped the person enjoy the mealtime and to avoid food going cold. People’s care plans and staff training records included references to the importance of nutrition and hydration.

We saw that people’s health, nutrition, fluids and weight were regularly monitored. There were well established links with GP and pharmacy services offering a single point of access for people.

Good

# Is the service caring?

## Our findings

Throughout our inspection we saw that members of staff spoke to people in a respectful and friendly manner and addressed people by their preferred name. One person said, "The staff are lovely. They are are very kind and do things for you."

A relative told us, "The staff here are a world apart. They can't be faulted."

The provider had a Service User Guide which emphasised the rights of people to be treated with dignity, to have privacy and to be able to exercise choice. This was also reflected in the home's policies and procedures and formed the basis for staff training.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences. Care records included details such as personal achievements, places visited and family relationships. At the time of inspection staff were updating people's care records with a section called "Life Story", with printed photographs as well as a description of the person's life from their perspective and with the help of relatives.

Care records explained to staff how people wished to be supported as well as including detailed interventions and outcomes when delivering care to people. Care staff were familiar with people's care plans and a keyworker role was in place which helped ensure that any changes to people's needs could be identified and communicated to all staff quickly.

Staff at the home had recently undertaken a three month programme on dementia with a view to becoming 'champions' for dementia care. This included looking at improving the layout of the home, becoming more person-centred in their interactions with people and improving general awareness amongst all staff in the home. One member of staff told us, "For it to work we all have to be part of it together, care staff, managers, cleaners, everyone."

We saw that this had already had a positive impact on the care at the home, for example with regard to ensuring the environment allowed free and unrestricted movement, activities being introduced such as Yoga and creative arts which were designed to encourage movement and discussion and the development of personalised life histories of people to enable better interaction between people and care staff.

People retained as much choice as they were able and staff respected their decisions. Throughout the day we saw that people had access to all communal parts of the home and their own rooms. Some people chose to spend time in their room, others chose to sit in quiet areas or move freely around the units. People told us it was their choice to spend time alone in their rooms and that staff respected their wishes. We observed staff carrying out regular checks on people who preferred to be alone and offered drinks and snacks.

Visitors were free to visit without undue restriction and we were told that this was welcomed as relatives often worked and had various distances to travel to the home.

We listened to how staff spoke with people and found this was professional and relaxed, and included friendly chit-chat between staff and people who used the service. We saw how people who used the service responded positively to the interaction. Staff responded promptly when asked a question and took time to explain their actions.

Care records contained information about the way people would like to be cared for at the end of their lives, if the person wished to discuss these matters. We were told by the deputy manager that health care professionals and family representatives had been involved in discussions to make sure people received appropriate care at the end of their lives, and that these discussions happened when it felt right to the person.

We saw several cards and letters written to the staff by relatives which commended the care that their loved one had been given, particularly at the end of life.

Good

# Is the service responsive?

## Our findings

We were told by relatives that the staff attend promptly when people needed them. We saw that people's requests for assistance throughout the day were responded to promptly and that call bells were responded to within a reasonable timeframe.

People and their relatives were also very positive about the way the staff and manager responded to requests for information, dealing with any concerns and supporting them in any individual request. One relative told us, "The staff and manager are always there to talk if you need them to."

People's needs were fully assessed prior to becoming resident in the home and at regular intervals thereafter. We looked at care records and saw that they contained assessments relating to weight, mobility, and healthcare including medicines, eating and drinking, behaviour and independence. People's cultural needs and religious preferences were also taken into account as were any specific requirements or lifestyle preferences. We saw that this also included how much or little social life people enjoyed. This enabled staff to be aware of people's temperament and to avoid placing them in stressful situations.

People told us they were able to come and go as they pleased, including when to get up or go to bed. The home also supported people to maintain relationships with family, relatives and friends. This was achieved through an open door visiting policy, regular meetings for relatives where they could share information and ideas, and involvement in the care plans of people.

The home had a senior care staff responsible for overseeing the activities within the home. We saw a full programme of activities for people which were prominently advertised and displayed. There were photos of activities and trips that had already taken place displayed in the entrance hall.

The senior care staff explained that where people did not wish to join in group activities staff would support people on an individual basis, sitting with them or reading. Good relationships with the local community were established with visiting representatives from various churches as well as external activities workers.

People said they felt confident that any problems or complaints that might arise would be dealt with by the management in a satisfactory way. A copy of the complaint's procedure was displayed near the main entrance to the home. This procedure told people how to complain, who to complain to and the times it would take for a response. No complaints had been received by the home or by CQC in the previous 12 months.

Good

# Is the service well-led?

## Our findings

The provider had an effective system to regularly assess and monitor the quality of service that people received.

People were very positive about the culture and atmosphere in the home. One relative told us, “It’s a lovely atmosphere. The staff are friendly and calm.”

Staff told us that they could talk to the manager about anything and she would listen and be supportive and they were reassured by this. Staff said if they were concerned about the treatment of anyone they would have no problem in reporting it to a senior care staff or the manager. Staff also felt that the atmosphere and teamwork was good. They were able to describe the aims and objectives of the home and the emphasis was on the idea that it was the person’s home.

The area manager was able to describe the vision of the home in the context of the organisation’s wider programme. Part of the strategy for the coming 12 months was to strengthen and develop the identity of the home as a clear specialist service for people with dementia and to continue to embed the learning from the dementia work they had recently undertaken.

The leadership, management and governance of the organisation assured the delivery of high quality person centred care, supported learning and innovation and promoted an open and fair culture. Staff had a good understanding of the ethos of the home and quality assurance processes were in place.

The home’s policies and procedures focussed on the rights of the individual person and were clearly written to enable staff to understand them and apply them. Examples included safeguarding and whistleblowing, complaints, supervision, care planning, medicines administration and emergencies. There were regular audits of the home which were theme based and related to the regulations that the home was subject to. Audits included the environment and maintenance of equipment, staffing levels, care of people, medicines, safeguarding, comments and concerns and feedback from people.

The manager and staff maintained a focus on keeping up to date with best practice through participation with groups such as Skills for care and the National Care Homes Association and through programmes such as pilot schemes in care for people with dementia.

Records in the home were held securely and confidentially.