Central and Cecil Housing Trust

Homemead

Inspection report

28 Park Road
Teddington
Middlesex
TW11 0AQ

Tel: 02089775002
Website: www.ccht.org.uk

Date of inspection visit:
22 October 2018

Date of publication:
22 November 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Homemead on 22 October 2018. The inspection was unannounced. We had previously carried out a comprehensive inspection in August 2017 where the overall rating was Requires Improvement.

Homemead 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.

Homemead provides accommodation and personal care for up to 26 older people with dementia. At the time of our inspection there were 23 people living in the home. The home is situated in its own grounds and has three floors, served by a lift.

At the previous inspection in August 2017 we found that the service was not meeting all the quality standards and was rated "Requires Improvement" in the key areas of safety and well-led. The inspection rated the service overall as "Requires Improvement".

We asked the service to provide us with an action plan for improvement and we monitored improvement during this inspection. At this inspection we found that the provider and registered manager had made the necessary improvements to their service.

At the previous inspection we found that people were not always supported in a safe way when receiving their medicines. There were some occasions where people were not always given their medicines on all days and that the recording of medicines used was not always accurate.

During this inspection we found that the management of the recording of medicines had improved. We found that daily medication audits were completed and fed into a weekly audit, completed by one of the senior management team.

At the previous inspection we found that people were not always supported in a safe way at night due to the numbers of staff on duty. There were occasions when people had to be left unattended whilst staff were carrying out other duties.

During this inspection we found that the night staffing had improved because the provider had increased the numbers of staff on duty. This meant that people were more frequently monitored and have their needs met sooner.

At the previous inspection we found that the service had systems and procedures in place to help deliver high quality care. However, it did not always use its audits and information to make improvements or address issues that needed resolving.

During this inspection we found that the service had improved the way it used its quality assurance systems to help managers and staff understand what was important to people and how the service could develop and improve.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the home and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Care staff could describe how they would report incidents of concern and records showed that training in safeguarding people had been updated.

Staff provided attentive care to people and risks to people's health, safety and welfare were well managed. Risks had been assessed and where appropriate contributed to the person's overall 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.

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

People and their relatives spoke positively about the care and support provided by the staff working at Homemead. A relative's view was that there could be more stimulation for those with the mental capacity to benefit from it.

There was a consistent team of staff working at the home who were appropriately trained. There was some dependency on agency staff but efforts were made to minimise this using bank workers and overtime.

The home ensured that wherever possible people were asked for their consent before care plans were agreed, medicines given or access to their rooms or personal information was requested. Records of signed consent forms were contained in people's care records including Do Not Attempt Resuscitation (DNAR) forms where people had requested these.

People received nutritious meals and could choose from a variety of dishes which took people's cultural and religious preferences into account. At night people could request snacks, including cereal and toast, as well as having plenty of fluids such as tea or juice. However, we noted that no liquid was provided during one lunch session until after the meal was eaten. This was discussed with the quality and compliance manager and we were satisfied that this was an error that would be rectified.

People's privacy and dignity were respected and promoted. There was a positive culture of inviting and encouraging people to socialise and take part in activities. However, people's wishes were respected and some chose to spend time in their room at various times of the day.

Bedrooms were personalised with people's belongings, such as ornaments, family photographs and small pieces of furniture. People received personal care either in their own room or bathrooms with doors closed. During our inspection we observed how staff interacted with people who used the home and found it to be

respectful and sensitive. Examples included referring to people by their preferred name and knocking and waiting before opening doors to bedrooms or bathrooms.

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.

The home demonstrated good management and leadership through having an experienced registered manager in place with the support of a deputy manager and senior staff members leading on each shift. The registered manager understood their responsibilities and was supported by a wider managerial team.

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 were protected from the risk of abuse and harm because staff had received a thorough recruitment process and had been trained in safeguarding people.

People received their medicines in a safe manner and there were good infection control procedures in the home.

People had been assessed with regard to any risks to their health or safety. These included their mobility, emotional well-being, health and nutrition. Risk assessments were used as part of the overall care planning.

Is the service effective?

Good

The service was effective. People were supported to have their assessed needs, preferences and choices met by staff with the necessary skills and knowledge.

Staff understood the relevant requirements of the Mental Capacity Act 2005 and the rights of people to make their own choices where possible. Where people lacked capacity, staff acted in their best interests.

People were supported to have enough to eat and drink. Meals were appropriately spaced and flexible to meet people's needs and people had a diet that was balanced and nutritious.

People were supported to maintain good health and had access to healthcare services which offered on-going healthcare support.

Is the service caring?

Good

The service was caring. Positive caring relationships were developed with people using the service and they were treated with kindness and compassion in their day-to-day care.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive. People received personalised care that was responsive to their needs.

The service had systems and guidance in place to enable people to raise concerns and for those concerns to be listened to and learned from.

Is the service well-led?

Good

The service was well-led. Quality assurance systems were being used by the provider to evaluate and improve their practice.

The service demonstrated good management and leadership through the registered manager, deputy and team of senior staff.

The registered manager and staff promoted a positive culture that was person-centred, open, inclusive and empowering.

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.

The inspection took place on 22 October 2018 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection, their area of expertise was residential care for older people.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law. We used this information to plan the inspection.

The provider had 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.

During the inspection we spoke with 10 people using the service and two visiting relatives. We also observed staff supporting people during the inspection. We spoke with five care staff, including team leaders, the deputy manager, the registered manager, the quality and compliance manager and operations manager. We also spoke with a visiting nurse.

We reviewed a range of documents and records including; five care records for people who used the service, three staff records, as well as other records related to the management of the service.

Good

Is the service safe?

Our findings

At the previous inspection we found that people were not always supported in a safe way when receiving their medicines. There were some occasions where people were not always given their medicines on all days and that the recording of medicines used was not always accurate.

During this inspection we found that the management of the recording of medicines had improved.

New daily medication audits were completed by morning and night shift team leaders. Any discrepancies were identified in the comments/actions section. This was fed into a weekly audit, completed by one of the senior management team. Any issues were added to the Homemead action plan, together with deadlines for the action, identify a responsible individual and provide evidence that the action has been completed.

In addition, a medicines competency assessment was carried out every quarter and medicines refresher training had a high take-up at 97% of the staff team.

The medicines trolley was securely locked and was stored on the ground floor. We observed a team leader administering medicines and recording these. They were able to demonstrate how medicines were administered to people and this was done in a safe, competent and caring manner. Medicines administration records (MAR) were accurately completed and up to date.

This ensured people received their medicines in a safe way.

At the previous inspection we found that people were not always supported in a safe way at night due to the numbers of staff on duty. There were occasions when people had to be left unattended whilst staff were carrying out other duties.

During this inspection we found that the night staffing had improved because the provider had increased the numbers of staff on duty. This meant that people were more frequently monitored and had their needs met sooner. During the day, between 8am and 8pm there were a minimum of two senior care staff with three care assistant staff on duty. From 8pm till 8am the night staffing had increased, with one team leader and three care workers supporting people.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the home and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. One person referred to the deputy manager and told us "he makes time to listen." Another said that the home was "a calm place".

Staff were supported with information to guide them in the event of a safeguarding concern being identified. The home had policies and procedures on safeguarding and whistle blowing and staff training had been updated and refreshed.

Staff were able to tell us the procedure and actions they would take in the event of a safeguarding allegation, which centred on swift verbal reporting of concerns followed by a written record. Staff were aware of the role of the local social services department in safeguarding matters.

Risks to people's health, safety and welfare were well managed. Risks 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, choking, mobility, moving and handling, pressure care, physical and emotional health. These then formed part of the persons 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.

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 home. The recruitment process included details of previous employment, checks made under the Disclosure and Barring Scheme (DBS) and reference checks.

Training records showed staff had received training and guidance to enable them to care for people in a safe way. In addition to safeguarding training, training also included first aid, moving and handling and fire safety. Staff had been trained to use specialised equipment, such as hoists, safely. This helped people and staff to feel reassured when using such equipment.

The premises were free from hazards and were clean. There was a personal evacuation plan in place in case of emergencies.

There were procedures and policies in place to control infection. All areas were clean and hygienic. Staff had received infection control training and records confirmed this. Quality assurance monitoring checks were carried out regularly on both infection control and medicines management to ensure that people received safe care.

Good

Is the service effective?

Our findings

People spoken with were happy with the support provided by the staff working at Homemead. One person told us, "I like it here, it's a lovely place to be. Everyone's friendly and the food is good." Another person said that they felt they were "living in a civilised place." One relative told us, "I can't fault it. Staff were good with [my relative]. It took a while for [my relative] to settle down but that's now in the past and it's all good now."

People were supported to have their assessed needs, preferences and choices met by staff with the necessary skills and knowledge. Staff told us they had opportunities for on-going training and there was a system in place to make sure staff received relevant mandatory training that was kept up to date. Records showed that staff had undertaken training across a number of areas. In addition to those already mentioned other training included dementia awareness, mental capacity, first aid, equality and diversity and person-centred care.

The latest audits of training and supervision showed that there was a 97% rate in staff completing all training and a 93% rate in ensuring staff received regular supervision.

Staff told us, and records confirmed that they were supported by the registered manager and senior staff both through formal one to one supervision meetings and more informal day to day contact. During these meetings issues were raised, performance was discussed and training was arranged. There were regular staff meetings and handover meetings where information regarding the home and the care of people could be exchanged.

The home ensured that wherever possible people were asked for their consent before care plans were agreed, medicines given or access to their rooms or personal information was requested. Records of signed consent forms were contained in people's care records including Do Not Attempt Resuscitation (DNAR) forms where people had requested these.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider carried out mental capacity assessments for people where it was believed they lacked the mental capacity to consent about their care and treatment. Staff demonstrated a good understanding of the MCA act and consent to care. Where appropriate, people had advocates acting on their behalf, where the home used the Kingston Advocacy Group.

The provider had a system in place to monitor the progress of any DoLS application and their status. This

meant that the provider was proactive and conscious about ensuring people's rights were upheld.

Staff had completed MCA and DoLS training that helped them to understand issues around capacity and support people effectively. Throughout our inspection staff offered people choices and supported them to make decisions about what they wanted to do.

People told us they enjoyed the meals provided to them and could choose what they wanted to eat. One person told us, "The food is very good and it is varied." A relative said, "The carers are lovely and [my relative] likes the food."

We sampled the food at lunchtime and found that what was on the menu was what was available on the day. We saw that people had a choice from the main menu, and those who did not wish anything from the menu would have a specific alternative meal provided. People could eat where they found it most comfortable and communal dining areas were designed to allow small groups of people to eat together

Lunch was provided in two sittings, one sitting for the more abled people and one for people who required more support. We observed staff supporting people to have their meal and this was done in a quiet and unhurried manner. Meals were nutritiously balanced and presented in a way that encouraged people's appetites.

We noted that there was a lack of homely items such as condiments and napkins on one table, and that the people who were being assisted on that table did not have anything to drink during their meal, but received one after. We discussed this with the management team and were satisfied that this would be looked into and resolved.

People's health needs were met. Health action plans addressed people's past and current health needs and staff kept accurate records about people's healthcare appointments and any action required. There was information about each person which helped hospital and other clinic based staff understand how best to support a person, should they ever need to attend a hospital.

We saw that the home worked well with other agencies such as pharmacist, GPs, social services and health services. During our inspection we saw and spoke with a visiting nurse who spoke positively about the care provided to people in the home.

The registered manager and staff had regular contact with external health professionals such as nutritionist, GP, physiotherapist, community mental health team, dentist, optician, chiropodist, the falls clinic, community and palliative nursing services.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring towards them and felt that staff had positive caring relationships with them. One person told us, "I like it here. There's always company on hand and you don't have to sit alone in your room." Another said that there were "bright nice people living here."

During our inspection we observed how staff and people interacted with each other and how they spoke with each other. We found that staff knew people well, understood their diverse needs and abilities and spoke with them in a kind and respectful manner. Staff supported people in an unhurried manner, moving with people at their own pace and allowing enough time for people to do what they wanted to do.

Activities in the home, along with other events such as mealtimes or appointments for administration of medicines were offered in such a way that people understood to the best of their abilities that they had a choice.

We found that people were involved in making decisions and planning their own care. Care plan reviews and risk assessments took the views of people and their relatives into account. This was complemented by the short "This is me" description of people, which highlighted the main important areas of someone's life history as well as their likes and preferences. These preferences took into account people's religious and cultural needs, for example with regard to food and spiritual practice.

Throughout the day we saw and overheard behaviour and conversations between people and staff which focussed on staff making sure that people understood what was happening and could make choices.

Staff spoke confidently and positively about how they tried to work together to provide a caring environment. One member of staff explained, "At handover at the start of day, we are allocated a small group of residents and we are responsible for ensuring that we monitor how they are doing. However, that doesn't mean we ignore everyone else. If any of us sees anyone who needs a hand, we provide that person with whatever they need and then inform the allocated worker."

Another member of staff told us, "I just love working here because I know these residents as well as my own family, and it does seem that we are one big family."

The home had a "Resident of the day" system. With only 26 people living in the home this meant that everyone had this opportunity once each month. This was a day when someone would be given greater individualised care, including doing things or going somewhere that was special to that person. People and relatives were aware of this system and confirmed that it took place.

Bedrooms were personalised with people's belongings, such as ornaments, family photographs and small pieces of furniture. People received personal care either in their own room or bathrooms with doors closed. During our inspection we observed how staff interacted with people who used the home and found it to be respectful and sensitive. For example, before entering a bedroom or bathroom, staff knocked and waited

before opening the door.

Elsewhere in the communal and public areas of the home were photos of events that people had participated in, information about activities and staff who were on duty and these were clearly visible.

We listened to how staff spoke with people and found this was relaxed and casual as well as appropriately professional, with staff addressing people by their preferred name. Staff responded promptly when asked a question and took time to explain their actions. For example, one member of staff was engaged in discussing the book of plants and flowers the person had. If the person could not find the right words to describe what they wanted to say the member of staff encouraged them with patience and gentleness.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People could take part in a range of planned activities, either indoors or outside, which ranged from art, music, exercises and trips.

Care records were based around the individual support needs of people. Care plans were all up to date and were evaluated on a monthly basis. This helped to ensure they contained up to date information for staff to support people more effectively. Depending on people's individual needs and risk assessments care records would include sections on mobility, behaviour, nutrition, moving and handling and tissue viability.

We observed, and people confirmed they could 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.

One initiative that the home had developed was a singing group which was made up of people living in the home. This started out as a conventional activity with someone encouraging a sing-a-long but had now attracted some people to form their own group. The deputy manager described this as an example of how, by making sure people were involved directly in the planning of activities, ideas could be developed in exciting ways.

We saw people engaged in activities during our visit, including a yoga session which was led by someone who lived in the home with the assistance of a DVD.

We found that there were lots of positive opportunities for people. However, most of these opportunities took place in the main lounge. This meant that sometimes the noise levels were quite loud and activities competed for attention, especially with conflicts between TV programmes and radios which were operating at the same time on occasion.

We recommend that consideration is given to greater utilisation of other spaces in the home in order that quiet activities do not compete with loud or energetic ones.

One relative told us that they felt there could be more thought given to providing more stimulating activities for those people who have full mental capacity, such as book club or language group. In addition, rather than big group trips to parks and buildings, perhaps more individual activities such as trips to the local shop to buy small items and have a coffee. We fed this back to the management of the home for their information.

The home made use of appropriate technology, both for people's benefit as well as enabling the service to be more effective. There was internet access in the home for people and visitors and the home had some tablets, such as iPad, for people to make use of, or to help care staff share common interests.

In addition, the home subscribed to an internet "cloud" based health and safety management application

which enabled staff to monitor and develop their health and safety awareness from any device.

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. There had been no complaints within the last 12 months.

Good

Is the service well-led?

Our findings

At the previous inspection we found that the service had systems and procedures in place to help deliver high quality care. However, it did not always use its audits and information to make improvements or address issues that needed resolving.

During this inspection we found that the service had improved the way it used its quality assurance systems to help managers and staff understand what was important to people and how the service could develop and improve.

We saw quality assurance systems which covered all important areas of the service related to safety, person-centred care, staff development and people's involvement in their care and activities. The management team used these audits by sampling a different floor each month or sometimes weekly, and any actions required were recorded and followed up.

There was a good understanding between the registered manager and the deputy manager regarding their designated roles. The deputy manager was very focussed on dementia-related care and day to day staff management whilst the registered manager worked with the operations manager and quality and compliance manager with overall development of the service.

Staff told us there was a positive and open culture in the home which enabled people to speak openly and seek support where required. One staff member told us, "Things are a lot better from a couple of years ago. We have a good way of working and the managers are really supportive."

People and their relatives also spoke positively about the management team and the culture of the home. One person told us that "the boss is lovely and takes time to listen." A relative told us how the manager and staff had listened to their concerns about their relative's mobility and had arranged a change of room. "They could not have done enough. They listen to you and they really get involved in trying to reassure you."

The management team also used audits and monitoring to learn from mistakes and to think about ways to improve their service. One example was a serious incident that had occurred some years ago which had resulted in training for staff which included scenarios related to that incident.

Policies and procedures emphasised the importance of people's rights to make their own choices, to be respected and to privacy. Information and guidance was displayed publicly as well as in the form of a brochure which described the sort of lifestyle people could feel they were entitled to.

The home demonstrated good management and leadership through having an experienced registered manager in place with the support of a deputy manager and senior staff members leading on each shift. The registered manager understood their responsibilities and was supported by a wider managerial team.

CQC registration requirements, including the submission of notifications and any other legal obligations

were met, and records were held securely and confidentially.