The Shaw Foundation Limited

Homefield House Nursing Home

Inspection Report

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Contents

Summary of findings

Overall summary

Homefield House Nursing Home is a care home providing accommodation for up to 24 people, some of whom are living with dementia, and who require personal and healthcare. At the time of our visit 19 people were living there.

The service was divided into four separate flats each with six bedrooms, a bathroom, kitchen/dining room and a lounge. Each flat had its own garden. People could also use a central arcade adjoining each flat for eating meals, meeting with visitors or walking around as they wished.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law with the provider.

People who lived at the service, who were able to talk with us, said they felt safe at Homefield House and we observed safe care being given. Staff understood how to protect people. There had been previous concerns from adult social services that staff in the home had failed to report a possible abusive situation quickly enough. Since then the service had improved and any possible abuse had been reported to adult social services and to CQC. This ensured relevant agencies worked together effectively to keep people safe.

Risk to people's health and wellbeing and risk due to environmental factors had been assessed and staff acted on this guidance to ensure people were protected from harm as far as possible.

There were sufficient staff on duty to meet people's needs. People were provided with information about their care and treatment and we found staff understood the requirements of the Deprivation of Liberty Safeguards, with systems in place to protect people's rights under the Mental Capacity Act 2005.

Staff had a good understanding of people's interests and preferences and respected them. They asked permission before they provided care. Where people lacked capacity to consent to their care or treatment staff consulted with relatives and acted in the person's best interests.

People's health and care needs were accurately assessed to ensure the service was appropriate for them. People were provided with effective support which was in line with their assessed needs.

The environment was appropriate to meet people's diverse needs. The home had specialist equipment, including hoists and beds, which helped staff to move people safely and maintain people's comfort.

People said the staff were kind and caring. We observed staff assisting people with their care in an unhurried manner and saw people's privacy was respected.

People felt able to complain and were confident their concerns would be listened to. However better records needed to be kept of these so the service could always demonstrate they were following their complaints procedure.

The management structure of the home gave clear lines of responsibility and accountability. There were good quality monitoring systems in place which helped to ensure that the service continued to achieve its aims and objectives.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe because people were protected from abuse and avoidable harm.

People who were able to say said they felt safe and we observed safe care being given.

Staff were trained in how to keep people safe. Risks to people's health and welfare were effectively assessed and staff took appropriate action to ensure these were minimised.

There were safe recruitment procedures in place and sufficient staff on duty to meet people's needs.

Where people did not have capacity to consent to their care and treatment the service had acted in accordance with the Mental Capacity Act 2005 to ensure this was in the person's best interest.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. Senior managers within the organisation understood their responsibilities to comply with this legislation and were taking steps to ensure applications were being made when a person they were looking after was being deprived of their liberty.

Are services effective?

The service was effective because people's care, treatment and support needs were accurately assessed.

People were provided with sensitive support that was appropriate to their health and care needs.

The environment was appropriate to meet people's diverse needs. The home had specialist equipment, including hoists and beds, which helped staff to move people safely and maintain people's comfort.

Are services caring?

People were treated with dignity and respect.

Staff knew people's wishes and preferences and ensured the care provided reflected them.

We observed, and people told us people's privacy was respected and staff were kind, helpful and caring.

Summary of findings

Are services responsive to people's needs?

The service was responsive because it was organised so it could meet people's needs.

People were consulted about their care and treatment. Where they were unable to make decisions themselves we found they were made in people's best interest and in accordance with relevant legislation.

People felt able to raise any concerns or complaints. However better records needed to be kept so the service could always demonstrate they were responding to people's complaints in accordance with their complaints procedure.

Are services well-led?

The service was well led because the management team assured the delivery of good personalised care.

There was a registered manager in post and the service had taken steps to ensure effective systems were in place to seek people's views, monitor the quality of the home and the care provided, and make changes to improve the overall service.

Summary of findings

What people who use the service and those that matter to them say

We asked one person whether they felt safe at the service. They said they did. They said there had been a time when they had not felt safe but staff had looked into this and talked with them about it. This helped to make them feel safe again. We asked another person if they felt safe and they said "everything's alright."

One person who was able to tell us said they were satisfied with the care and support they received. Visitors were also satisfied with the service. One relative said, "Homefield has consistently provided an outstanding level of individual care to [my relative] and other residents".

One person who was able to talk with us said they were treated with respect. All of the visitors we spoke with said the staff were kind helpful and caring. One said "The staff are outstanding; their hard work and commitment is very much appreciated".

People said, in general, they were kept informed of their relative's wellbeing. One person said "We are kept updated on any issues relating to [my relative's] general health and there are regular reviews regarding how [my relative's] care needs can best be met as the illness has progressed". However two relatives we spoke with said they were not aware of their family member's care plans.

One person said they had been unhappy a while ago and staff had sorted this out. All relatives we spoke with said they understood the complaints procedure and felt able to raise any concern. One person said "Any minor concerns have always been addressed quickly and communications between the home and ourselves cannot be faulted". Another relative however had not been satisfied with the response received.

Homefield House Nursing Home

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

At our previous inspection in April 2013, no concerns were identified.

Before our visit to Homefield House Nursing Home, we reviewed the information we held about the service. This included previous inspection reports and notifications of significant events that had occurred since our last inspection.

For this inspection, the team consisted of a lead inspector and an expert by experience. The expert by experience had personal experience of services for older people.

We visited the home on 1 May 2014. We talked with two people who lived at Homefield House and six visiting relatives. We also received written feedback from a relative. We spoke with six staff. We used the short observational framework (SOFI) which is a specific way of observing care to help us to understand the experience of people who could not talk with us. We looked at all lounge and dining rooms and in some people's bedrooms (with their permission). We looked at records, which included people's care plans and records relating to the management of the home, as well as information given to us by the senior manager on the day of our visit.

Are services safe?

Our findings

The service was safe because people were protected from abuse and avoidable harm.

We asked one person whether they felt safe at the service. They said they did. They said there had been a time when they had not felt safe but staff had looked into this and talked with them about it. This helped to make them feel safe again. We asked another person if they felt safe and they said "everything's alright."

Most people were not able to tell us if they felt safe because they were living with dementia which affected their verbal communication and ability to answer direct questions. For this reason we spent time observing care being given. This helped us to form a view about whether people were being safely cared for. We saw one person who was sitting in a recliner chair had their position changed to make them more upright before they were helped to take a drink. This helped to ensure they drank safely.

Staff we spoke with understood their role and responsibilities about how to keep people safe, for example if they suspected abuse. Staff said they had been trained in how to safeguard adults when they started working at Homefield House. Staff were also aware of the whistleblowing procedure which enabled them to take any serious concerns outside the home if they felt they were not being effectively dealt with. Training records showed staff had received training to ensure their knowledge in this subject remained up to date.

We looked at a recent safeguarding issue that had been investigated by the local authority. This related to an unexplained injury to a person who lived at Homefield House. Staff had worked cooperatively with adult social services to investigate possible causes of the injury and to minimise the risk of this reoccurring. During the investigation it was apparent staff had not notified adult social services as quickly as they should have when they had first noticed the injury. They had also not notified CQC. On this occasion they had not followed agreed safeguarding procedures.

We looked at subsequent records of other incidents which could be safeguarding concerns which the service would need to notify adult social services and CQC and saw they had done this without any delay. This helped to ensure the relevant agencies and services worked together to prevent possible abuse.

Identified risks to people's health and wellbeing were managed safely. We looked at four people's care records and found they all contained risk assessments. These helped staff to assess and to take action to minimise risks when people were particularly vulnerable for example, of their skin becoming sore and broken. We saw action had been taken to reduce the possibility of this happening, for example by providing people with pressure relieving equipment and by staff applying creams regularly where needed.

Environmental risks were considered. Everyone who lived at Homefield House had a personal emergency evacuation plan (PEEP.) These were easily accessible and provided staff with guidance about the action they should take in the event of an emergency such as a fire.

We saw staff reduced the risk of spread of infection by regularly washing their hands and by wearing disposable gloves and aprons when they were supporting people with their care.

Staffing levels were sufficient to meet people's identified needs. We saw staff had time to assist people to eat and drink, to play games, to read to those who wanted this and to comfort a person who was distressed. People who were at risk of falling were accompanied and others were monitored on a regular basis.

On the day of our visit the deputy manager was on duty along with six care staff. They were supported by domestic staff which included one staff who was responsible for cleaning, one who was responsible for the laundry, a cook and a catering assistant. This helped to support the 19 people who were living at the service. One care staff was on duty in each of the four units and other care staff moved between units to assist where necessary. The nurse on duty had overall responsibility for all of the four flats, for example to administer medicines. We looked at the rosters for the week of our visit. These showed that staffing levels did not fall below these levels. Regular bank staff were used to fill in for annual leave or sickness where staff employed

Are services safe?

at Homefield House could not cover these gaps. This amounted to four care shifts during the week we looked at, and so people were mainly supported by staff who knew them well.

We spoke with one staff member who had been recently employed. They said they had not started until checks to establish their good character and confirm their previous experience had been completed. We looked at two staff files and found checks were undertaken to safeguard people who used the service before they began work. These included references; criminal record checks and evidence that trained staff were registered with the relevant professional body to practice. This showed there were safe recruitment processes in place.

Most people who lived at Homefield House had been assessed as not having the mental capacity to consent to aspects of their care and treatment, for example to understand what medicine was being given to them. We saw, where this was the case, best interest decisions had been made on their behalf. This showed staff had acted in accordance with the Mental Capacity Act 2005 to help protect the rights of people who were not able to make decisions for themselves.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. When this is the situation a service needs to apply to a supervisory body, in this case adult social services, to ensure that the proper processes are being followed. A recent court decision has provided a definition of what is meant by the term 'deprivation of liberty'. A deprivation of liberty occurs when the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. The staff in the service understood their responsibilities following the court decision and were taking steps to ensure applications were being made where necessary.

Are services effective?

(for example, treatment is effective)

Our findings

One person who was able to talk with us said they were satisfied with the care and support they received. Visitors were also satisfied with the service. One said "Homefield has consistently provided an outstanding level of individual care to mum and other residents". Others were not able to say how effective the service was in meeting their needs and so we observed care being given. We spent half an hour observing three people receiving support with their lunch in a dining room. We saw people were provided with effective care. For example, people had food which met their assessed needs and which was appropriate to their dietary requirements such as soft food which was easier for them to eat. They were also given straws or adapted beakers to help drink and therefore maintained as much independence as possible.

We found the service was effective in assessing and planning people's care and treatment. People's needs had been assessed before they moved in to establish whether Homefield House would be suitable for them. Information had been gathered about people's physical and mental health needs from people and their families as well as professionals, for example, care managers from adult social services. This helped to ensure people's care and treatment needs had been assessed before they moved and ensured that Homefield House would be suitable for them.

After the staff understood what care, treatment and support needs people had they drew up a plan of care for each person. We looked at four people's plans of care. They were up to date and contained sufficient detail to ensure staff provided effective support. Staff confirmed plans of care were accurate and up to date. They said if there was a sudden change in a person's condition this was discussed during handover so that staff coming on duty would be aware of what to look out for.

Staff acted to ensure that people's wellbeing was maintained. For example, one person who needed a hoist to move safely had information in their care plan about what sort of hoist was needed and the size of sling required. We saw staff were using the equipment as described. People were provided with other equipment to ensure they were comfortable and being cared for effectively, for example, pressure relieving mattresses were correctly adjusted according to people's weight. This helped to reduce the risk of them developing pressure ulcers**.** We saw creams had been applied as prescribed. This helped to prevent the possibility of people's skin breaking down. Records we checked for the past week for one person who was prescribed creams twice a day showed that this had been done apart from one day where records showed this had been applied once.

Records were kept of when staff supported people to clean their teeth and to confirm staff had assisted people to wash or bathe every day. We saw these had been consistently completed.

Some people could get distressed or agitated as they had problems thinking and remembering. We saw, where this was the case, staff had taken advice from specialists such as the community mental health team to guide staff in how to help people keep calm. Staff had, for example increased their observations of a person who could become distressed so they could intervene quickly to calm them and we saw this was being done on the day of our visit.

Staff acted to ensure people's health was effectively maintained. For example, staff regularly monitored a person's blood sugar levels. There was information to guide the staff about the range of acceptable blood sugar levels. Care notes also included symptoms to look out for if the person had blood sugar levels which were too high or too low to help staff to identify when the person's condition was not stable. When readings fell out of the safe range staff had liaised with a specialist nurse and had adjusted the person's dose of insulin as necessary.

People lived in an environment which met their health, care and support needs. The service was divided into four separate flats each with six bedrooms, a bathroom, kitchen/dining room and a lounge. Each flat had its own garden. People could also use a central arcade adjoining each flat for eating meals, meeting with visitors or walking around as they wished. Bathrooms were large enough to allow access to wheel chairs and there were adapted bathing facilities. There was plenty of space for staff to sit alongside people to support people effectively with their meals.

Are services caring?

Our findings

According to the home's website their ethos is to be respectful of customers' dignity and privacy whilst maintaining professional levels of care, catering, safety and related support. This showed the values that were important to the service and we saw people were treated with dignity and respect during our visit.

One person who was able to talk with us said they were treated with respect and we observed staff knocking on their door and waiting for an answer before they came into their bedroom.

All of the visitors we spoke with said the staff were kind helpful and caring. We also saw caring and respectful support being provided on the day of our visit. We observed one staff member walking up and down the central arcade with a person who lived at Homefield House. According to their care records this person could easily become distressed. The staff member was reading from a book. When they stopped the person said "keep going" and they did .The person looked calm and was clearly enjoying this support.

We observed staff holding hands or linking arms whilst walking with people and speaking gently to them. We also witnessed banter and laughter between some people and staff. We observed one person who lived at the service was repeatedly asking for a drink. Staff did not acknowledge them initially as they were assisting other people. They responded within ten minutes. Staff helped them with a cup of tea and supported them to drink this. Shortly after the person changed their mind and did not want the tea. Staff said "You like cranberry juice don't you" Staff then helped them to drink some cranberry juice. The person said "that's nice." Staff provided calm and unhurried support holding their hand whilst they were helping them. This followed guidance in the person's plan of care and was appropriate and respectful support. We saw, when people were unable to express themselves clearly verbally; care staff continued to communicate with them effectively and could often interpret what they were trying to say when we could not. This showed that the staff knew people well and were able to care for them appropriately.

We saw, when people became upset; they were given prompt support by staff. This helped to reassure them.

People's care records contained information about where people were born, their interests, memorable life events and their dreams and wishes. They also contained a list of people's likes and dislikes and information about what people and things were important to them .This helped to ensure staff provided caring support and was particularly important when people were unable to talk about this themselves. Care records provided staff with guidance about people's preferences. For example one said "leave (the person) to soak for at least ten minutes (when in the bath)". This helped to ensure that people's preferences and wishes were respected.

One person told us their religion was very important to them. When we met them they were reading their bible in their room. They said a priest visited them regularly. We saw people's spiritual needs were considered as part of the planning of their care. This showed the staff understood and supported people's wishes to follow their religious beliefs.

People's rooms were decorated with photographs and other objects which were relevant and meaningful to them. All bedrooms were single and so people had privacy if they wanted it. We saw people spent their time in their room, in the lounge and dining rooms in the flats or in the central arcade. They could also spend time with their visitors in any of these areas. This helped to ensure the staff respected people's wishes to be alone or with others as they wished.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found the service was responsive as people's needs and preferences were taken account of, so people received personalised care.

There was information available to people and their relatives when they were considering using the service. People could drop in to have an informal discussion and to look around the home. There was also information available on line about the service. The website described what was provided at Homefield House; signposted people to the relevant Care Quality Commission inspection reports; described facilities; and explained the admission process and charges. This helped people and their families to make informed decisions about whether the service would be appropriate for them.

People's care plans were detailed and made reference to how people wished to be supported and cared for. Care records showed that people's preferences were considered. For example, people's food likes and dislikes were identified. One person's record said they "liked finger food" and we saw this was provided. We observed that other people were asked about how they wanted their food and drink given to them.

Night time care plans were detailed enough for staff to understand what people's individual preferences were. For example one person's care plan said they liked their bedroom door closed and their light left on. We could not always check whether staff carried out the guidance contained within people's care plans; however we observed good interactions with staff getting smiles from people. This indicated staff had responded appropriately to their requests.

Staff said most people were unable to use their call bells if they needed help when they were in their bedrooms. We spoke with one person who could use their call bell who confirmed it was always accessible to them and said staff answered in a reasonable time when they pressed it.

For others who would not be able to use a call bell to summon assistance, we observed staff checked on them regularly when they were in their bedrooms to see if they needed anything.

Where people had capacity to consent to their care we saw staff respected this. We saw consulted with all people before they carried out personal care tasks for example to cut their fingernails or to help them with a drink. Records showed that people's ability to keep their bedroom key had been considered. This helped to ensure people remained as independent as possible and continued to be provided with choices about their daily living needs.

Relatives had been kept informed when people were unwell or if they had health appointments such as a visit to the dentist. One relative said "We are kept updated on any issues relating to [my relative's] general health and there are regular reviews regarding how [my relative's] care needs can best be met as the illness has progressed". However, two relatives we spoke with said they were not aware of their family members' care plans.

Where people lacked capacity to consent to some elements of their care or treatment, this had been assessed and relatives were consulted to ensure staff provided care in the person's best interest. We saw relatives had signed to confirm they had been consulted for example when staff took a photograph of their family member. We saw staff had also talked with involved professionals, for example social services staff, which also helped to ensure they were acting in people's best interest.

Staff we spoke with said they had recently received training in the Mental Capacity Act 2005. They said all staff were expected to complete this training. They said the training had provided examples to help them to understand their roles and responsibilities in respect of this legislation.

Care records contained information about people's hobbies and interests and staff we spoke with used this information to help to tailor activities in line with these. For example one person who enjoyed reading was having a book read to them.

Staff said there was "plenty to do for people." They said they had time to be with people and we observed they did this, both sitting and talking with them in small groups and interacting with individuals.

We observed quoits were being played with one staff and three people who lived at the service. They looked like they were enjoying this and staff ensured all were included and involved.

The service was responsive to concerns and complaints, although record keeping regarding these needed to be

Are services responsive to people's needs?

(for example, to feedback?)

improved so the service could consistently demonstrate they were responding to people's concerns in line with their complaints policy. One person said they had been unhappy a while ago and staff had sorted this out.

Staff said they would be comfortable to raise any concern if they had one with managers and said they were confident their concern would be responded to. All relatives we spoke with said they understood the complaints procedure and felt able to raise any compliant although one had not been satisfied with the response received. This was being considered further with input from adult social services. We saw a record of complaints had been kept when people had put their concerns in writing. When people had voiced verbal concerns or complaints these had not been recorded. This meant the staff could not always demonstrate they were following their complaints policy. A senior manager said this shortfall had been recognised and systems for complaints were going to be improved.

Are services well-led?

Our findings

The service had a management structure which supported the smooth running of the home. There was a registered manager in post.

There was a deputy manager and team leaders who were responsible for leading each shift. All were registered nurses. On the day of our visit the registered manager was not present but we observed senior staff reacted with other staff in a positive way and managed the shift well. For example staff asked for advice and support and this was provided. A senior manager from the organisation was also at the home to provide further support in the absence of the manager.

We spoke with four staff about the support and training they received. They said the training was good and was a mixture of e-leaning, formal teaching and group discussions. They also confirmed they had supervision about every three months.

We saw a training schedule which showed there were regular training courses which covered key health and safety areas such as fire safety and safeguarding. This helped to ensure staff had suitable skills and competencies to meet the diverse need of people living at the service.

We considered how the service ensured there was an open and responsive culture so it was run in line with people's wishes. The service held relatives meetings about every three months. The most recent relatives meeting had taken place in February 2014. Four relatives and five staff attended. They discussed areas of joint interest such as activities and staffing levels. Relatives were also told of visits made by professionals who were responsible for placing some people at Homefield House. The visiting professionals had made a number of recommendations and these were shared with relatives with explanations of what action had been taken as a result to improve the service.

The registered manager's office was in a different building but staff in charge of the shift did not use this. This meant they could more easily observe what was happening in the home and were available for people who lived at the service and their visitors when they were needed.

Staff had the opportunity to feedback any views or ideas they had about how the service was run. during monthly meetings. The most recent staff meeting had taken place in March 2014. Twelve staff members had attended. Staff who were unable to attend had access to minutes of these meetings. During this time staff were reminded when they needed to attend refresher training and were given a different policy to read every month.

We saw there were good quality assurance processes in place. Certain aspects of the management of the service had been delegated, for example one staff was responsible for infection control. These delegated responsibilities helped to ensure these areas were monitored effectively.

A record was kept of accidents and incidents that had occurred within the home. These records had been reviewed by the registered manager who signed to confirm they had taken action where required to reduce the risk of reoccurrence.

The registered manager completed a weekly report for senior staff in the organisation to inform them of any issues which had occurred. For example if there had been concerns about anybody's pressure area care or if there had been any safeguarding concerns within the service. This helped the organisation to monitor and ensure appropriate action had been taken to keep people safe and well.

We saw there was a detailed plan of proposed improvements to the home. There were dates when action needed to be completed and details of who was responsible for each improvement. The senior manager said they were continuing to monitor the action plan to ensure the service continued to meet its aims and objectives.