Care Quality Commission

Homestead House Limited

# Homestead House

## Inspection report

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Tel: 01603486098

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 22 May 2018.

At the last inspection carried out in 2015, we found that the provider was rated 'Good' in all areas except for well-led, which was rated, 'Requires improvement'. This was because they had not submitted notifications when required. At this inspection we found that the registered manager had sent us notifications as required by regulation.

Homestead House is a care home providing personal care to up to 21 people, some living with dementia. There is one shared room. Some rooms have en-suite toilet facilities and there are communal bathroom facilities available. At the time of our inspection there were 17 people living in the home.

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

There was a registered manager in post. 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.

Risks to people were not always fully identified, assessed and mitigated. This included risks associated with falls and people's conditions, as well as the management of some prescribed items. 'As required' (PRN) medicines were not always planned for and recorded appropriately. Not all of the staff had a thorough knowledge of safeguarding.

People did not always receive care that was in line with their individual preferences and these were not always recorded. There were some activities on offer for people, but these were not organised and planned in line with people's preferences.

The auditing systems in the home did not always identify areas where further improvement was needed. These included medicines audits and audits for overseeing the content of care plans.

Medicines were stored securely at a safe temperature and were administered by trained staff. There were systems in place to keep the environment safe for people, however improvements were needed to the systems to mitigate risks associated with legionella.

There were enough staff to meet people's needs and recruitment procedures which contributed to keeping people safe.  Staff had training in areas relevant to their roles and new staff shadowed more experienced staff.

There was not a thorough understanding of the Mental Capacity Act (MCA), as mental capacity assessments were not always decision-specific, and best interests' decisions had not been recorded.

People were supported with meals and drinks, however they were not always supported fully in line with their care plan. Meals were not always nutritionally balanced, and people did not always have access to a drink. However, people were offered drinks regularly throughout the day.

People's needs were assessed prior to moving into the home. People had care plans which guided staff on how to meet their needs, although these were not always detailed with individual preferences and updated.

Staff knew people and their needs well, and adapted their communication to support people living with dementia.

Staff supported people to maintain their independence as much as possible, and supported their privacy and dignity.

People and their families knew how to complain and felt comfortable to raise any concerns with staff. Staff involved people in their care.

There was training in end of life care planned for staff, and the registered manager discussed people's wishes with them, when they felt comfortable to do so.

There was good leadership in place and staff worked well as a team. People were asked for their views on the service.

# The five questions we ask about services and what we found

We always ask the following five questions of services.

## Is the service safe?

**Requires Improvement**

The service was not always safe.

Risks to people were not always identified, mitigated and managed.

PRN medicines were not always fully planned for and recorded. Medicines were administered by trained staff.

There were enough staff and they were recruited safely.

There were environmental checks in place for health and safety of equipment and the home itself. Safety of water could improve.

## Is the service effective?

**Requires Improvement**

The service was not always effective.

The records around the MCA were not always completed as decision-specific assessments were not carried out.

People were supported with their meals and drinks, however not always in line with their care plan.

Staff received training and support in line with their roles.

## Is the service caring?

**Good**

The service was caring.

People were supported by kind staff, and their privacy and dignity was supported.

People's family members were involved in their care where appropriate.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People preferences were not always met and were not always detailed in their care plans.

There were some activities on offer for people to engage with, however these were not always organised in line with people's preferences.

The staff responded to people's needs in a timely manner and communicated with one another about changes in people's needs.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Auditing systems did not always identify areas where improvement was needed.

There were systems in place to gain feedback from people to improve the service.

There was good leadership in place and staff worked well together.

Care Quality Commission

# Homestead House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was an unannounced comprehensive inspection and took place over one day. The inspection team consisted of one inspector and one 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.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with four people living in the home and three family members. We were aware that some people had more ability than others to express themselves. We also spoke with four staff members, including a senior care worker, two care workers and the registered manager, as well as the director.

We looked at a sample of medicines administration records (MARs), three people's care plans in detail, and certain sections of other care plans. We reviewed records relating to how the home was run, for example, health and safety records, incident records and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

We last inspected this service in October 2015 and it was rated 'Good' in this area. At this inspection we found that there were some shortfalls and improvements were required in this domain. Therefore, it is now rated, 'Requires Improvement' in safe.

Not all staff had a good understanding of safeguarding. The staff we spoke with were not able to explain the different types of abuse which could happen to people, and how they would report any concerns outside of the organisation. We saw that staff received training in safeguarding. They told us the training they received was a combination of computer-based learning and face to face. However, we were not assured this was fully effective with regards to safeguarding, which meant there was a risk that concerns could be overlooked by staff.

All the people we spoke with said they felt safe living in the home. One person said, "On the whole I am quite happy here, I would rather be at home, but I do feel very safe, all the girls here are careful and at night time there is someone watching over you." A relative said, "I feel my husband is safe here, there are people around he is not on his own." These examples demonstrated that people had confidence in the staff to promote their safety.

Risks to people were not always systematically assessed based upon current best practice guidance and actions to mitigate were not known and in place. For example, we saw in one person's room, a prescribed medicine was not safely stored. The medicine was prescribed to thicken drinks for people with swallowing difficulties who may be at risk of aspiration. The person told us they administered this themselves, and didn't need it all the time. We looked at the person's care plan and found that the medicine had been prescribed in specific amounts, and a speech therapist had advised this should be followed carefully. Staff told us nobody in the home administered their own medicines. There was no risk assessment in place for the person to manage this medicine for themselves. There was no record of a conversation with the person and their relatives to inform them of the risks associated with not following the guidance properly should they wish to make this decision.

Furthermore, the unsecured medicine presented a risk of accidental ingestion or misuse for others living in the home, especially for those living with advanced dementia. The person's relative told us that another person living in the home had gone into the person's room before because they had become disorientated. We spoke with the registered manager about the medicine and they told us they did not wish to take away the person's choice. Whilst this was positive, we were concerned that the risks were not considered, and it was not clear whether the person was making an informed choice. The registered manager agreed to create a risk assessment if needed, and remove the medicine from the person's room initially and ensure it was administered by staff.

There was not always detailed guidance in place within people's care plans which mitigated the risk of people falling. One person had fallen twice recently. They had no falls risk assessment in place. Their plan said there were control measures in place, but no additional information about what these were of how staff

could help mitigate the risk to the person were in place.

There was a lack of guidance based upon best practice for staff to follow in the event of falls. Where people had hit their head, there were regular checks advised. However, no guidance for when people sustained a skin tear through a fall. Furthermore, the care plan was not updated with the guidance about any ongoing treatment for skin tears. This meant that the skin tear was not always monitored closely to ensure it was improving and properly treated. There were pressure mats in use for some people, which alerted staff when they mobilised and meant they could be supervised if mobilising alone. This helped to mitigate the risk of falls to some people.

There were not always details in people's care plans which sufficiently guided staff on mitigating risks associated with people's conditions, for example, for diabetes. There was no specific risk assessment which guided staff on concerns relating to diabetes management; such as checking people's feet regularly, or monitoring blood sugar.

We recommend the provider seeks guidance from a national recognised body to ensure that best practice is followed.

Risks associated with people developing pressure areas were managed well, and there were no serious pressure ulcers in the home. Where people required assistance with repositioning and using prescribed creams to manage their skin, staff supported them with this.

There were some 'as required' (PRN) medicines which did not have an attached protocol. These are especially important for people who may not be able to communicate if they require something. This included mind-altering medicines used for agitated behaviours being given regularly without recorded justification. We saw for one person, they were receiving a PRN of this kind every day, and there was no protocol which guided staff on how, when, and why, to give it. Therefore, we were not assured that PRN medicines were always appropriately administered. Following the inspection, the registered manager sent us a general guide to administering PRNs and told us they felt staff knew how to administer these. However, protocols need to be person-specific to be safe and effective based on guidance from the prescribing physician.

Medicines associated with a high risk outcome if not given appropriately, for example, pain patches, were not recorded on a body map. This meant there was some risk that the old patch may not be removed, and the patches may not be rotated and that can lead to skin irritation. Therefore there was a risk that the person may not receive it accurately. However, we spoke with one staff member administering medicines, and they knew where the patch had last been put on and where it was needed for the next time. The front sheets for the MARs did not always contain information such as the person's photograph, allergies, and additional suggested important information in line with best practice. The risk was partly mitigated as the staff team knew people's needs well.

People were safely supported to take their medicines by staff who were trained to administer them. One person told us, "The staff give me my tablets, if I have a headache or something like that I only have to ask and they give you them." A relative also told us they were kept informed of any changes with regards to medicines. Medicines were stored securely at a safe temperature. We looked at medicines administration records (MARs) within the home and saw that staff signed when they had given medicines. There were no missed signatures, which indicated that the medicines had been given as prescribed.

All the people and relatives we spoke with said that staff were available when required. There were enough

staff to ensure that people were safe, and the rota reflected this. Staff also confirmed to us that they were able to meet people's needs and cover shifts when needed due to absence, so they did not run short.

Staff were recruited in a way that contributed to keeping people safe. This included requests for work history, references and a DBS check (Disclosure and Barring Services). This meant that staff were checked in order to see if they had a criminal record, and that they were suitable to work with people.

Staff used safe infection control practices when they worked with people, for example using gloves and aprons when delivering care. People did not raise any concerns about cleanliness in the home, and one person said their room was clean. We saw that most rooms were clean, however, there were some areas of the home which required a more thorough clean, for example some carpets and plugholes in the communal bathrooms contained debris.

The home had systems in place to mitigate risks to people associated with fire, gas, electrical equipment, asbestos and lifting equipment. However, they did not have a risk assessment for legionella, and were not regularly checking hot and cold water temperatures, descaling and flushing disused taps. These processes help to mitigate the risk of legionella bacteria appearing. They had had a legionella test done yearly which had not raised any concerns. We fed this back to the proprietors.

We looked at incident records in the home, and found that whilst some of these contained further action to take following an incident, for example where someone fell, some were limited in further action. We found that there was not a regular analysis of incidents and accidents within the home so that any trends could be identified. The service told us they had an ongoing general service improvement plan for the home, and this had included recent refurbishments that had taken place, as well as a new call bell system.

Requires Improvement

# Is the service effective?

## Our findings

We last inspected this service in October 2015 and it was rated 'Good' in this area. At this inspection we found some improvements were required. Therefore, it was rated 'Requires Improvement' in this area.

People, especially those living with dementia could be encouraged and facilitated to drink and eat more. One person told us, "The food is fine, I get enough and you can always ask for more." However, two people told us they felt there were not always enough snacks on offer. The registered manager and the director told us that people received extra snacks at least twice during the day and in the evening. We saw during the afternoon that people received some cake. We observed that people were offered a hot drink mid-morning and in the afternoon. However, we did not see people being offered biscuits or snacks at either time, despite some people's care plans stating they should be offered regular snacks. There were jugs of squash available within the communal lounge area. People who were not able to get themselves a drink, did not always have one within reach. However, they were offered drinks regularly, and a choice of squash at lunch time.

We observed the mealtime experience at lunch time. Most people had jacket potato, mash potato and carrots, some people having this with meatballs. It was not a nutritionally balanced meal as there were two types of potato given to everyone. At the time of serving lunch, rice pudding was the only dessert offered. There was a menu written on the board which had two choices of the meal and dessert, and the registered manager told us people had a choice. They were asked what they wanted earlier in the day. However, this was not always helpful to those living with dementia, and there were no supporting visual ways in which staff supported them to choose. We saw that where someone changed their mind at lunch time and did not want their meal, they were able to choose an alternative, which they received. People's mealtime experience could be improved to ensure they receive a balanced nutritional meal that meets their needs.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people had DoLS authorisations applied for within the home, and two of these had been authorised.

There was not a full understanding of the MCA. People had capacity assessments but these were not decision-specific, for example when people had pressure mats to alert staff to movement. Therefore, it was not always clear that their capacity had been assessed for this decision and that the decision had then been made in the person's best interests, with involved family members. We discussed the need for these with the registered manager, as well as the importance of assessing people's capacity to consent when there was any doubt, for example, to PRN medicines.

Staff we spoke with confirmed how they gained consent from people who had problems communicating, and gave examples of supporting people with variable mental capacity. The registered manager told us they involved some family members in decisions about people's care, and we saw they had signed care records on behalf of people. Where it was written in some people's records whether they had a family member with Lasting Power of Attorney for Health and Welfare, the service had not requested and kept copies of these so we were not able to verify these.

People's needs were properly assessed by the registered manager before they moved into the service. This was so that they could ensure that any equipment required to support the person was in place, and that they could meet their needs. The registered manager communicated closely with people's social workers when needed to ensure that they coordinated care as much as possible. This included when supporting people to move between services.

One relative told us, "I think the staff have the right skills from what I have seen, I visit every day in the morning and my sister visits in the afternoon." Staff we spoke with told us they received training relevant to their roles, and were supported to undertake further qualifications within health and social care, such as the Care Certificate. Other training included fire training, manual handling, dementia care and Mental Capacity Act (MCA). We saw that staff understood how to use equipment safely to support people to move. However, we found that they did not all know about safeguarding and this training could be improved. There were no formal competency assessments carried out with staff to ensure that they understood and implemented training they received in their roles.

All of the staff we spoke with told us they received regular supervisions. These are meetings with a senior member of staff where staff can discuss their roles and gain feedback. They said they felt well-supported at work. The staff we spoke with had been working in the home for more than a year, however they told us that when new staff started they shadowed more experienced staff and underwent the training provided. The registered manager told us they observed staff practice regularly and carried out additional supervision if they identified any concerns.

People could access healthcare services when needed, and the people we spoke with confirmed this. One relative said, "[Family member] had a little bit of a fall they told me that when I walked in, they got the doctor out to check." We saw that records were kept with notes and recommendations from healthcare professionals when they visited, for example dieticians, speech therapists and community nurses.

We looked at the how the environment met people's needs. There was one room which was shared between two people using the service. We found that the first occupant had more floor space to accommodate a bed and furniture, and the second occupant had less space for a bed and furniture allowing very little room for personal space and privacy. A curtain divided the two areas, however there was a large gap underneath the curtain which limited privacy. One of the people in the room expressed a wish to have their own room, which the registered manager had informed us would be possible when another room becomes vacant. There were new ensuite rooms to the first floor which were well equipped and nicely furnished. All lounge areas were bright with appropriate types of chairs, laminate flooring and a TV. There was a smaller area off the lounge with access to the garden where people sat and enjoyed the outlook and the fresh air from the opened windows. There was signage to support people living with dementia.

Good

# Is the service caring?

## Our findings

We last inspected this service in October 2015 and it was rated 'Good' in this area. At this inspection we found the service continued to be caring and was rated 'Good'.

People and families felt comfortable to discuss anything they needed to with staff. One person told us, "I find [staff] approachable I can ask them anything." One relative we spoke with told us they spoke with staff about anything they wanted to talk about with regards to their family member's wellbeing. They said, "[Registered Manager] is about a lot I would speak to her or any of the staff if I had concerns, but if they have concerns they ask us if that is normal for [relative]."

We asked people if staff were caring. One person told us, "Generally speaking I would say yes, they mainly are polite." Another person said, "[Staff] are caring and very patient, I would soon tell them if they weren't." A relative said, "As far as I can see, they always seem very patient, I have never heard a sharp word. Even if the staff are busy they say I will come back to you, they prioritise their work." This was also reflected by the other relatives we spoke with.

However, we observed care interactions throughout the day which were carried out in a gentle and patient manner. The atmosphere was calm and unrushed and staff were present in the lounge, and the proprietor and manager were also present throughout the day. We saw that when staff supported people to eat they did so in a kindly, unrushed manner.

A relative told us how staff supported one person to gain some independence back following a stay in hospital. They said, "When [relative] came here [staff] got them walking again." People had equipment to support them to be as independent as possible. For example, one person had adapted cutlery to help them to eat their meals.

The registered manager spoke with people and families regularly and involved them in their care by ensuring they gained feedback from them. Relatives we spoke with told us that staff informed them of anything important concerning their family member. One relative explained how staff had involved her in getting some suitable clothes as their family member no longer found the same items comfortable.

Personal care was carried out in private and staff knocked on doors before entering people's rooms. We saw that when staff were supporting people to see if they wished to use the toilet, this was done in a discreet manner.

All of the staff we spoke with told us how they adapted their communication to support people to make choices when they needed this. For example, supporting people living with dementia to choose their outfit for the day.

Visitors were able to visit the home when they wished outside of mealtimes and late evenings. The director and the registered manager told us this was because some people preferred to get into their pyjamas and

be in the communal lounges in the evenings. The visitors we spoke with told us they felt they could visit regularly when they wished.

Requires Improvement

# Is the service responsive?

## Our findings

We last inspected this service in October 2015 and it was rated 'Good' in this area. At this inspection we found the service had some shortfalls and was rated 'Requires Improvement'.

We gathered mixed information about how individualised the care provided to people was. There was limited information about how people preferred to receive their personal care, and when, in their care plans. Furthermore, some people told us their preferences were not always met. One person said "I would like more showers, I had a wet room at home so I am used to showering every day but once a week would be nice, I have had one this year not this month this year. I like to shower in the evening." Another said, "Some of the staff are a bit slap dash in how they wash you I have to ask can you wash my back, some of them are excellent." We spoke with staff about supporting people with showers, and they assured us that they did offer people showers regularly according to their preferences. We spoke with the registered manager about recording more information about when people refused to have personal care, as this was not currently recorded.

For two people who were sharing a room, it was difficult for the service to be fully responsive to their needs. For example, staff told us that when one person got up in the night they woke the other person too. They said, "The [other person] has to wake up too which is not fair." The room was laid out as such that one person had to go through the others' side of the room to come and go as they wished.

Although there was information about people's life histories in their care plans, it was not clear that this was used to develop activities in line with people's interests. Staff told us there was regular visiting entertainment in the home, such as a monthly musician. Activities were planned on a daily basis, and staff did activities with people when they had time. These included activities such as board games, ball games and bingo.

We received mixed feedback from people about whether they had enough to do. One person said, "I like to stay in my room as I can't converse with anybody in the lounges." Another person told us, "We do rely on the television a lot, I did have an organ and I miss it, I like music, we could do with a bit more, when the person comes and plays the organ I am there. I do get a bit bored sometimes." We observed some task-led practice. Throughout the day there was very little conversation between staff and people; conversation only happened when a task was being carried out or an instruction.

On the day of our inspection, staff played bingo with people which not everybody was able to join in with, but some people engaged with. In the afternoon the registered manager was encouraging a game of connect four with a person. The staff celebrated people's birthdays with them in the home, and held seasonal events such as a Christmas party. People were supported with their spiritual needs when they wished, for example a local vicar visited the home to carry our communion with people.

Staff responded to people's needs in a timely manner. There was a call bell system which people could use to call staff if they needed them. One relative said, "If [family member] wants the toilet whilst I am here I just

go and ask and they assist within two or three minutes." We saw that staff assisted people when they needed.

Staff responded appropriately when people's needs changed. One person said, "One day I wasn't feeling very well and [staff] dealt with it." Where people were not able to communicate verbally, staff knew them well and were able to respond appropriately. One relative told us, "The staff know the signs to look out for." This was with regard to if they required support with personal care. Many of the staff working in the home were long-standing staff members which meant they knew people's needs well. Staff communicated with one another about people's changing needs, both verbally and through a message book.

People had access to additional services when they required, which supported people's wellbeing. One person confirmed, "The chiropodist comes and the hairdresser, I have my hair done weekly."

People and their families told us that the registered manager asked them if they were happy with the care. One relative said, "[Registered manager] comes in and asks if everything is ok." People we spoke with said they knew who they would complain to. The home had not received any recent formal complaints. There was a system in place to deal with complaints to ensure they would be resolved appropriately.

The registered manager told us that they discussed end of life care with people when they agreed to discuss this. They told us they were planning additional training for staff in this area in order to develop end of life care plans more thoroughly.

Requires Improvement

# Is the service well-led?

## Our findings

We last inspected this service in October 2015 and it was rated 'Requires Improvement' in this area. At this inspection we found the service continued to have some areas for improvements and was rated 'Requires Improvement'.

At the last inspection we found that the service had not always informed CQC of notifiable incidences. At this inspection, we found that the registered manager was aware of notifications they were required to send in and we had received notifications when required.

There were audits in place to monitor the service, however, not all of these were fully effective. They had not identified some areas in which the service had not kept up with current good practice. There was an audit of medicines which checked all of the stock levels of the medicines. It did not check the documentation around them, for example, PRN protocols, front sheets, and the MARs. Therefore, the registered manager had not identified areas that needed improvement.

There were audits in place for reviewing the care plans. However, these did not always check these in line with the care that people were receiving and that people had risk assessments and care plans in line with their needs. Furthermore, they had not identified whether the care plans contained all of people's preferences about the care they received, for example with regards to activities, social stimulation and personal care. They did not identify where people required decision-specific mental capacity assessments and best interests' decisions. The registered manager did not demonstrate that they were aware of some areas of current best practice with regards to older people's needs. This meant they were not always able to drive improvement in these areas.

There were no formal competency checks carried out to ensure that staff were working as expected, although spot checks were carried out. These however, were not recorded. The director told us they observed staff manual handling and delivering care, and they recorded these checks only if there was a problem which meant further supervision was needed. However, it had not been identified that safeguarding training was not always effective.

There was a questionnaire which was sent to people and relatives anonymously for the service to gain feedback. One relative told us, "What they do here is questionnaires, if there is anything I write on there." We looked at a sample of these questionnaires and found they gave predominantly positive feedback about the service. There was also a suggestion box which people and visitors could use to put in feedback and ideas on how to improve the service. The director gave us an example of how they had used this feedback to improve security of the home. We saw that the home had received many compliments from people on the care they delivered.

The people and relatives we spoke with said they would recommend the home to others. There was a pleasant atmosphere within the home.

There was good leadership in place. The registered manager and the director had run the home together for several years and many staff had worked there for several years with them. The registered manager was consistently visible to people, relatives and staff and approachable for them to speak with. People we spoke with confirmed they knew who the registered manager was, and we saw that the registered manager communicated with everyone in communal areas during our inspection. A relative told us, "I have knocked on the managers door if I want to see her and she will come out or tell me she will be out soon." All the staff we spoke with said they worked well as a team and that there was good management in place.

The registered manager told us they subscribed to various publications to keep up with current practices. The registered manager told us they attended conferences when possible for the National Care Association, and this supported them to keep up with best practice. They also told us they attended any externally sourced training with staff to ensure they remained up to date. Where needed, they worked in partnership with social workers and other agencies, sharing appropriate information to ensure people received suitable support. We concluded that the service needed to implement improved quality assurance systems with best practice in mind to ensure a good service was delivered.