The Shaw Foundation Limited

Homefield House Nursing Home

Inspection report

Homefield Way
Aldermaston Road
Basingstoke
Hampshire
RG24 9HX
Tel: 01256 33433
Website: www.shaw.com

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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?	Good
Is the service well-led?	Good

Overall summary

This inspection was unannounced and took place on the 23, 25 and 26 February 2016.

Homefield House is a nursing home which provides nursing and residential care for up to 24 people who have a range of needs, including those living with epilepsy and diabetes and those receiving end of life care. The home provides specialist support to those living with dementia.

The nursing home comprises of a large ground floor building set in secure grounds on the outskirts of Basingstoke town centre. The home comprises of four distinct areas which are off the central corridor to the home known as 'The Street'. The Street is a large, naturally lit area which runs the length of the home and has reading material, interactive items upon the wall, a fake bus stop to act as a focal and reminiscence point,

Summary of findings

sensory objects and chairs and tables for residents and visiting friends and family. The four distinct areas to the home each contain six bedrooms, a bathroom and toilet as well as a shower room with toilet, their own small kitchen, dining and living room. At the time of the inspection 19 people were using the service.

Homefield House does not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had started working at the home three months prior to the inspection and was already in the process of becoming registered with the CQC.

People were not always protected from the risk of acquiring an infection. Some areas within the home required additional cleaning and articles to support safe and effective hand washing procedures were not always available.

We have made a recommendation that the manager ensures that infection control guidance is reviewed and the appropriate equipment made available for staff to support people safely.

People were not always supported in their mealtime routine by staff who followed guidance provided in peoples care plans. Guidance was not always followed to support people in the most effective way.

Staff provided care to those living with dementia however the environment did not always support people to move around the home safely and to remain independent. Corridors were dark; there were limited signage to assist people to identify toileting facilities and the handrails were similar of the same colour of the walls. This would not assist those with limited vision as a result of their condition to be able to move effectively around the home.

We have made a recommendation that the manager seeks further guidance on the environmental factors which can be adapted to meet the needs of those living with dementia.

Relatives of people using the service told us they felt their family members were kept safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

Robust recruitment procedures were in place to protect people from unsuitable staff. New staff induction training was followed by staff spending a period of time working with experienced colleagues to ensure they had the skills required to support people safely.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such fire or floods which affected the delivery of care. Fire drills were documented, known by staff and practiced to ensure people were kept safe.

People were protected from the unsafe administration of medicines. Nurses were responsible for administering medicines had received training to ensure people's medicines were administered, stored and disposed of correctly.

People were supported by staff make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

People's health needs were met as the staff and manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

Summary of findings

Staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which were personalised to their needs and wishes. They contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives told us and records showed that they were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People knew how to complain and told us they would do so if required. Procedures were in place for the manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the manager.

The provider's values and philosophy of care were communicated to people and staff. Staff understood these and relatives told us these standards were evidenced in the way that care was delivered.

The manager and staff promoted a culture which focused on providing care in the way that staff would wish to receive care themselves. Even though the manager was newly in post they were providing strong positive leadership and fulfilled the requirements which would be associated with their role as a registered manager. The manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe. Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff who were encouraged to raise concerns with the manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People were not always protected from the risk of acquiring an infection. Infection prevention arrangements were not in place to ensure suitable handwashing facilities were available and the environment would remain clean.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

There was a robust recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

Medicines were administered safely by nurses whose competence was assessed by appropriately trained senior staff.

Is the service effective?

Requires improvement

The service was not always effective.

People were able to eat and drink enough to maintain their nutritional and hydration needs. The chef and staff knew people's preferences regarding food and drink. However guidance about how to best support people with their meal time routine was not always followed by staff. As a result people were not always supported to ensure they were able to participate in mealtimes.

People were supported by staff who had the most up to date knowledge available to best support their needs and wishes.

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal requirements of the MCA 2005 were met. Staff understood the principles of the Mental Capacity Act 2005 and the manager was able to show a detailed understanding of the Deprivation of Liberty Safeguards (DoLS).

People were supported by staff who sought healthcare advice and support for them whenever required.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff were motivated to develop positive relationships with people.

People were encouraged to participate in creating their personal care plans.

Summary of findings

Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People received care which was respectful of their right to privacy whilst maintaining their safety.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis with additional reviews held when people's needs changed.

People were encouraged to make choices about their care which included their level of participation in activities and where they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner in accordance with the provider's complaint policy.

Is the service well-led?

Good

The service was well led.

The manager promoted a culture which placed the emphasis on people receiving quality care from staff who treated people in the way they would wish to be.

The manager provided strong leadership and informed the Care Quality Commission about important and significant events that occurred at the location.

Staff were aware of their role and felt supported by the manager and the provider. They told us they were able to raise concerns and felt the manager provided good leadership.

The provider and manager regularly monitored the quality of the service provided so that continual improvements could be made.

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 function. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 23, 25 and 26 February 2016 and was unannounced. The inspection was conducted by an adult social care Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service, on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, their relatives and staff.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people, seven relatives, one nurse, five members of care staff, the chef, the activities coordinator and the manager. We looked at seven care plans, three staff recruitment files, two nurse recruitment files, staff training records and five medication administration records (MARS). We also looked at staff rotas for the dates 17 January to the 13 February 2016, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. During the inspection we spent time observing staff interactions with people including during activities and lunch time sittings.

The service was previously inspected on the 17 April 2013 and no concerns were raised.

Requires improvement

Is the service safe?

Our findings

Relatives we spoke with told us they felt their family members were safe living at Homefield House. One relative told us, "Oh yes, totally (family member is safe), absolutely no qualms."

However, working practices did not always ensure that people were protected against the risk of acquiring an infection. During the inspection it was raised by relatives that they did not always feel adequate procedures were in place to ensure the location was kept appropriately clean with the required resources to enable people and staff to practice safe infection control. One relative told us, "There are a few issues with domestic staff, toilets and things, no hand towels for over a week and I don't think there has been soap for five days…I put my hands down it's a bit sticky". Another relative said. "It (the home) has been a bit grubby…the cleanliness is getting better, they're putting down new carpets…since the new manager has come here it's been getting better, I've seen a cleaner not just some of the staff who've been on cleaning duties".

We found that the majority of the areas within the home were clean. However there were some identified areas which required additional cleaning which was brought to the manager's attention. The Street contained a visitor's toilet that was also accessible by residents and was seen to be used by all during the entire course of the inspection. On the first day of the inspection it was identified that there was no liquid hand soap in the dispenser to enable staff, visitors and relatives to appropriately wash their hands. Hand washing instructions and antibacterial gel were available to promote good practice and minimise the risk of infection however no hand soap was available. Two days later on the second day of the inspection, this missing soap had still not been replaced. It was identified that due to illness the housekeeper had been unable to complete manual work however other staff had been asked to assist with the general appearance and maintenance. The bathing and toileting areas within each 'house' in the home were viewed and on the first day of the inspection staining was noted to communally used toilet areas with unpleasant odours. Not all areas had handtowels to enable people to dry their hands effectively. On the second day of the inspection it was noted that the toilet items and bathrooms were cleaner and there were no unpleasant odours from the bathrooms, toilets and shower rooms.

Most staff had completed infection control training and we saw some evidence of safe infection control practices. Appropriate protective clothing such as disposable aprons were used when staff delivered people's care. Each of the four houses had its own sluice, which is wear soiled linen is washed, to ensure that soiled items had no need to be transferred long distances before it could be cleaned. A number of people living at the home were nursed in bed and were therefore more susceptible to illness as they were unable to support their own personal hygiene. Residents were able to move freely around the home which included in and out of people's rooms if doors were open. One resident had previously been diagnosed with Clostridium Difficile (known as C diff) which is a bacterium that can infect the bowel and cause diarrhoea. Spores from this bacteria can survive for long periods on hands, surfaces, (such as toilets) and clothing unless they're thoroughly cleaned and can infect someone else if they get into their mouth. The person who had this previously was an active person who enjoyed wandering around the home. Whilst there were not instances of infection related illnesses within the home there was a risk that people could be explosed to risk as a result of safe and correct handwashing items not being available.

We recommend that the manager ensures that the location's infection control guidance is reviewed and the appropriate equipment made available for staff to enable them to support people safely.

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns within the home. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert. Staff received training in safeguarding vulnerable adults and were required to refresh this training annually. The manager was aware of when a safeguarding alert was required. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for

Is the service safe?

example, communication, people's moving and handling needs and their fall risks both inside and outside the home. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Risks to people's care were identified, documented and staff knew how to support people's needs safely.

There were robust contingency plans in place in the event of an untoward event such as accommodation loss due to fire or flood. Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home. This provided an easy to follow guide for staff and emergency personnel. The PEEPS included information regarding people who required additional assistance due to their complex needs in the event of a fire. Staff knew the fire drill procedure and told us this was practised to confirm their understanding of the actions to take should the situation occur. If rooms were no longer suitable for habitation then people would be moved to a hospital or other homes within the county to ensure continuity of care. These plans allowed for people to continue receiving the care they required at the time it was needed.

During the inspection some relatives and staff raised concerns that staffing levels were not always sufficient to meet people's needs. The manager identified that the staffing levels consisted of one nurse and six staff during the day with one nurse and four staff working during the night. These staffing levels were based on people's health needs. Records and observations during the inspection showed that there been deployment of sufficient numbers of staff to meet people's needs safely. Where shortfalls in the rotas had been identified these had been supported by the use of agency staff. There had been occasions due to last minute reported staff sickness where agency staff had also been sought to provide assistance. The manager tried to ensure consistency of care by using a regular pool of agency staff and known agency staff were requested in order to provide a familiar face to those receiving care. Staff told us and records showed that they were still able to meet people's needs by prioritising the required care. A member of staff told us, "Nothing is being missed (when staff are sick) you do manage…it's our job to do it, it's sickness at the last minute, that's when we are short but it's not normally like that". Another member of staff told us, "We help each other, nothings being missed (in care delivery). People told us that they were receiving care when they required, one person told us, "(staff are) Always there and help if needed". A relative said, "Yes (there are enough staff) They always help each other if necessary". Another relative told us, "The arrangement works quite well…but of course I would always say more staff please".

A recruitment process had been ongoing and new care staff were due to commence employment the week following the inspection. This would assist staff and people by limiting the number of agency staff being employed to deliver care ensuring continuity of staff. This is important for those living with dementia who need to be able to recognise familiar faces. People were cared for by sufficient numbers of staff to meet their needs safely.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

People living at the home received their medicines safely. Nurses received additional training in medicines management and records showed that medicine administration records were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to competency assessments to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses and to ensure medicines were managed in accordance with current regulations and guidance.

Guidance was provided in people's Medicines Administration Records (MARS) for nurses on when the use of additional medicine would be appropriate. This is

Requires improvement

Is the service safe?

referred to as 'when required' medicines and can include additional painkillers. We saw that appropriate information was provided as to when this additional medicine would be required.

Medicines were stored, administered and disposed of correctly. There was a medicines fridge which was kept at the appropriate temperature. Records confirmed a safe temperature was maintained. The provider used a nationally recognised policy to ensure that controlled drugs were managed effectively. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented weekly by the manager, to check that records and stock levels were correct.

Requires improvement

Is the service effective?

Our findings

People we spoke with were positive about the ability of staff to meet their care needs. People said that they felt staff were trained and had sufficient knowledge and skills to deliver care. One relative we spoke with said, "From what I've seen yes they have….there is a team ethos here and they all seem to be on some sort of training". Another relative told us, "Several staff here are extremely competent who are very, very good with the residents, they're true professionals".

People and relatives were mostly complimentary about the food provided and most people were supported by staff during meal times. One person told us about the food, "It's very nice", another relative said, "It's absolutely wonderful, sometimes I come in and eat." Another relative told us about the food provided, "It's so-so, my (family member) is on a puree diet, the chef makes a brilliant effort, they know what my (family member) likes". One person said, "It's very good in here, they look after us well".

People were not always supported at mealtimes by staff who were patient and attentive to their needs. We saw one staff member failed to follow the appropriate guidance provided in a person's care plan to assist them to eat and drink. The guidance detailed talking and making eye contact with this person before assisting them by placing the food in their mouth. No conversation was made with this person and no attempt at eye contact made to encourage them to eat. This person was unable to communicate verbally and required eye contact from staff to ensure they were ready to continue with their meal. Another person was left during the dinner service when they required assistance. At the beginning of the lunch sitting staff began to assist this person however were called away to assist in another area of the home. This person then began to remove their food from the plate and placed this on the table in front of them. The manager attended to assist this person however had to leave to offer assistance elsewhere. This person was then left alone at the table taking food off their plate and began to show signs of agitation. These incidents were brought to the attention of the manager and were not repeated during the inspection.

The chef was aware of people who had specific dietary needs such as diabetic or those who required a pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained a visual appeal and was separated on the plates to allow people to identify what they were eating.

The Street, the main social area of the home, was an inviting large naturally lit area with reminisce items seen to be used by people and relatives during the inspection. However, the living accommodation, corridors, dining rooms and bathing and toileting areas were not designed or decorated to best support those living with dementia to live as independently as possible. The manager was aware of the need to enable the service to be more dementia friendly and had plans to develop the site appropriately. The corridors in the living areas were not very wide and despite windows at the end of the corridors and the provision of lighting the corridors remained dark. This meant that those living with dementia and associated eye sight deterioration could find it difficult to orientate themselves within their surroundings. The handrails were the same or very similar colours to the walls which did not easily allow people to identify a focal point to hold on to. Not all the toilets and bathroom doors had additional pictorial signage to make identification easier. There were not always specific destination points at the ends of each corridor with seating and views for people to spend their time. Carpets and flooring were not always appropriate for those with limited sight needs associated with those living with dementia. Changing colours and patterns of flooring can be disorientating for those who have limited visual capacity as a result of their dementia. However there were items available for use around the home which included cuddly toys and dolls for doll therapy. We could see that these were being used by people during the inspection and were used as a conversation point between people and staff.

We recommend that the provider seeks advice and guidance from a reputable source about developing a dementia friendly living environment.

People were assisted by staff who received a thorough and effective induction into their role at Homefield House. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. Staff had undergone training in areas such as Health and Safety, moving and handling theory and practical and safeguarding vulnerable adults. Most staff had achieved a Level 2 Certificate in Healthcare

Requires improvement

Is the service effective?

Support Services. This is a national accreditation for those who wish to work in the healthcare profession and includes training in a number of key areas including, infection prevention and control, cleaning, decontamination and waste management, record maintenance and providing care and support to people. This qualification is assessed using a portfolio of evidence, completing practical demonstrations and writing assignments.

Consent to care and care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People's freedom was not unlawfully restricted without the appropriate authorisation being sought. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager showed a comprehensive understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications and authorisations. Staff spoken with understood why DoLS were required.

Staff were able to describe when a best interest decision would be most appropriate. Best interest decisions are made when someone no longer has the capacity to make a specific decision about their life. Records showed that appropriate mental capacity assessments and accompanying decision specific best interest meetings had been held for people when they no longer had the capacity to agree to a certain course of action involving their care.

This included the use of bed rails for those who were being nursed in bed which had been signed by people and or their family member with a legal authority to agree to their use.

People were assisted by care staff who received support in their role. There were documented processes in place to supervise and appraise all care staff to ensure they were meeting the requirements of their role. The providers policy stated that all employees were to receive a minimum of six formal supervision sessions a year. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. Staff told us and records confirmed supervisions occurred every two to three months. There had been a period in November and December 2015 when some staff had not received a formal supervision due to the change in manager and deputy manager. However a majority of these missing supervisions had been held in January. Staff told us they were able to speak to their team leader, manager and deputy manager at any time if they required additional support. Processes were in place so that care staff received the most relevant and current knowledge and support to enable them to conduct their role effectively

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of illness could be identified. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Records showed that these were being completed showing minimal variations in weight suggesting they were supported to eat and drink sufficient amounts to maintain a healthy weight. Professional health care advice was sought and followed by staff which was evidenced during the interactions with the staff. For example people who had difficulty eating or swallowing, speech and language therapist's assessments had been requested and completed. One assessment requested that a specific thickener was used in this persons drink to prevent them from choking. The nurse confirmed the correct thickener which was being used to support this person and we could see it was being used during the course of the inspection. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to support staff on how to manage people living with certain conditions,

Requires improvement

Is the service effective?

such as epilepsy. Care plans detailed what the triggers and physical symptoms of these episodes were, what action should be taken and which health and social care professionals should be made aware. Records showed that staff were aware and knowledgeable on what action to take in the event of medical episodes and were documenting these accordingly.

Good

Is the service caring?

Our findings

People experienced comfortable and reassuring relationships with staff. Relatives and people told us that support was delivered by caring staff. One person we spoke with told us, "They (staff) are always helpful, they come back and check, are you feeling alright". Another person told us about the staff, "Very good really, no problem there, always there and help if needed". A relative told us, "We're like a family here".

Positive and caring relationships with people had been developed by staff. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people. One person began telling us about their family and incorrectly identified how many children they had. A member of staff was nearby and heard them provide the wrong details and was able to gently remind them how many children they had. This member of staff took time to support this person to remember correctly. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and gave them to respond appropriately. All the staff we spoke with told us the reason they most liked working at Homefield was caring for the residents. One member of staff said, "We like to do the best you possibly can to make them happy, you've got to respect them", another member of staff told us about their role, "I love it, I love the girls here and they're fab". Whilst staff were busy they continued to treat people with respect and showed a genuine care for people's wellbeing.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Guidance was provided in people's care plans to help staff identify when people who were unable to verbally communicate were distressed. This included the facial expressions and physical behaviours displayed and the actions to take during this period of unhappiness. One person was seen to be distressed during the inspection calling out for their family member. Staff approached this person and were kind, compassionate and gentle with their approach to this person. A relative told us, "They (staff) know when people are upset….but they give them 15 minutes and a chat and they're happy again". Staff told us they always had the time to support people when they were distressed and we saw this in practice.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day.

People were encouraged by the manager to personalise their rooms and living spaces. One relative told us, "It's important to give praise…we have a good room ad we've been able to decorate it and bring in our own furniture". People's bedrooms were decorated with people's own pictures and possessions reflecting their interests. People were involved in making decisions about how they wanted their bedrooms decorated; for example, one person showed us their recently replaced carpet in their bedroom. The manager told us it was the provider's intention to replace some of the flooring throughout the home and whilst a laminate or easy care flooring would have been easier to maintain carpet was what people wanted and she respected their decision.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in an office to protect confidentiality. During the inspection staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included making sure that people were suitable clothed and had their modesty protected when they were assisted with their personal care to and from the bathrooms and toilet. People were provided with person care with the doors shut and curtains drawn to protect their privacy. Staff were seen to ask people before delivering or supporting with the delivery of care.

Good

Is the service caring?

People were also respected by having their appearance maintained. Attention to appearance was important to people and noted in care plans. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked.

People had been supported to ensure their wishes about their end of life care had been respected and documented accordingly. Care plans provided personalised information for people regarding the support they required and their wishes about where they wanted to be. Care plans detailed the healthcare professionals who were required to provide assistance during this time. These plans were reviewed monthly to ensure that they were current and reflected people's latest wishes, needs and requests.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plan. People not able or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided.

People's care needs had been assessed and documented by staff before they started receiving care. These assessments were undertaken to identify people's support needs and care plans developed outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. One relative told us in relation to creating their family members care plan, "Yes and it gets reviewed, it (care plan) is there for me to look at any time I want, I'm doing a constant review 5 days a week".

Relatives with a Power of Attorney (POA) to assist in the decision making process were informed when reviews were happening to ensure their views could be taken into consideration. A person with a POA has the legal authority to make decisions on people's behalf. When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. When healthcare professional advice has been sought the information provided had been used to update people's care plans accordingly.

The provider sought to engage people in meaningful activities. Care plans detailed people's hobbies and previous enjoyments to help staff to encourage people to participate in as broad a range of social activities as possible. Care plans detailed people's particular social interaction needs and the need for activities to be completed with people on a daily basis. One person's care plan detailed that they enjoyed listening to a particular genre of music. Their care plan also documented that staff should not leave this person on their own for long periods as this would cause feelings of social isolation. During the inspection we saw that this person's favourite type of music was playing and staff sat with this person reading to them.

The home had an activities coordinator who had previously worked as part of the care staff team in the home so had a good personal knowledge of the residents and their preferences. They worked three days a week for a total of 16 hours a week. When they were not present in the home staff told us that they left activities for them to complete with people. The activities who sought to ensure people were engaged in activities and meaningful occupation. For people who were unable to leave their beds the activities coordinator would read to people and help them participate in a number of sensory activities. This would include massage, aromatherapy and providing soft toys to people to provide stimulation of holding a comforting item. A typical week activities rota was viewed which had defined activities from Monday through to Friday. This included sensory sessions, reminiscing, pamper sessions, ball games, craft, gardening and bingo. One member of staff told us, "In the afternoons I have time to sit and chat with people and that's an activity…from the moment I walk in people have having activity all day of some description with me, they're having an interaction". External agencies were also encouraged to visit the home to encourage people to experience new and different situations. The day before the inspection began a local petting zoo had been to the location which had been enjoyed by those who had participated. Stories of what animals people preferred to hold were spoken of with enthusiasm and people reacted by smiling when talking about the animals which had visited. People were also able to participate in external trips, such as visits to the coast for boat trips, to the London Eye, museums and trips on a local steam train. One relative told us they were encouraged to attend the external outings, "They (staff) do such a lot…we go on trips, oh yes, I love it". We saw a cake making session in one of the lounges which was attended by a number of people including relatives. People enjoyed the session, laughing and joking with staff. The activities coordinator adopted a tactile approach encouraging and supporting people to become involved. People taking part had varying levels of mobility and communication however all were included.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the manager to address any concerns. The provider's complaints procedure was available in the foyer which was accessible to visitors and relatives. This listed where and how people could complain and included contact information for the provider and the manager who could be contacted at any time.

Good

Is the service responsive?

The provider's policy stated that they would, 'Activity seek people's opinion regarding the quality of care received…compliments and complaints…will be used to improve the quality of the services and ensure compliance". Not all the relatives we spoke with felt that the provider took responsibility when they had raised complaints with them previously. Previous staffing level concerns had been submitted, investigated and responded to within the provider's complaints timescale however relatives did not feel that the answer provided a satisfactory response to their original complaint. We could see that the situation which had led to the complaint was an unusual and uncommon occurrence due to last minute staff sickness resulting in a staff member leaving the home which could not have been avoided. In relation to the everyday running of the home and quality of the service provided, people and relatives told us they knew how to make a complaint and felt able to do so if required.

Complaints had been recorded on the provider's computer system so they were accessible to review to identify trends or repeated incidents involving people or staff. Ten formal complaints had been received in the last two years which included unsubstantiated complaints of lost property and the quality of the food provided. We saw that the complaints had been raised, investigated by the manager and steps taken to address the causes of the complaints and were responded to appropriately in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

The manager was newly in post at Homefield House. They wanted to achieve and promote an open and supportive culture in the home. To do this they sought feedback from people using the service, their relatives and staff. People and relatives said they were very happy with the quality of the service provided. One relative told us, "It's (the home) brilliant"…"I can't praise them (staff) enough, it's wonderful…(family member) is more settled now and is happy and contented, I'm very pleased ". Another relative that us, "We're like a family here".

The manager was keen to promote a culture which was based on people and relatives feeling that the care was delivered by respectful caring staff who treated people as they wished to be treated themselves. This culture was reinforced with staff through supervisions and appraisals, training and every day observations conducted by the manager around the home. The provider had a philosophy of care which had been developed by the provider and was displayed for people to view. This included the standards of care that people should expect to receive whilst living in the home. Wellness, happiness and kindness were identified as key words which were integral to the delivery and the receipt of care people received. Staff we spoke with recognised the key principles of the philosophy, one member of staff told us, "My mission is to make my residents happy" Another member of said, "You've got to give people that total respect as you'd like yourself".

The manager was a visible presence to relatives and staff. Staff were positive about the manager and the support they received to do their jobs. They told us that the manager was open to their concerns and needs. Upon starting their role at the home they had been situated in a separate building within the grounds. The manager felt that this was a barrier to communication with people, relatives and staff and moved into the main building into an office accessed by The Street. This made that them more visible to people and was a recognisable face to visiting relatives. The manager also provided people with her contact telephone number and promoted an 'open door' policy of always been available to people. A relative told us, "It's important to give praise. On the whole management have been prepared to listen."

Staff said that they were able to approach both the manager and deputy manager and were confident that they would be proactive in dealing with issues raised. The manager was available for staff if they needed guidance or support. One member of staff said, "She gets involved…if we need support she's there. If we need something we go to our team leader, deputy or manager and something will be done". Another member of staff told us, "She (the manager) talks to me and I can talk to her whenever I have a problem, she has been very supportive when I've needed help".

The manager was able to evidence that they knew what was required of their role. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We use this information to monitor the service to ensure they respond appropriately to keep people safe. The manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance

The quality of the service people experienced was monitored through regular care plan reviews, and relatives meetings. The minutes for the last four relatives meetings were viewed which documented that people were kept informed regarding the redecoration plans for the home, general updates including requesting feedback on the care received by family members and the quality of the food provision. Positive comments were received during the last relatives meeting which had occurred in 2015, with one relative commenting that everything was wonderful and thanking everyone in the home for their support and they felt the home as 'lovely and homely'. A residents meeting was conducting during the inspection and observed. During this relatives were encouraged to participate in discussions about working practices within the home to ensure they were kept updated and had their views taken into consideration.

The provider also completed a number of quality assurance audits at the home to monitor the service provision. These included a monthly quality review by the provider's quality team and two monthly management reviews which involved a quality monitoring system audit by the area manager.

The monthly audits had been initially completed bi-annually and gathered evidence of compliance with the regulations from a range of sources which included audits of care plans, resident interviews, feedback from relatives and other stake holders, observation of practice, interviews

Good

Is the service well-led?

of the manger and staff as well as reviewing systems and administrative records. The provider felt that this was not sufficient to be able to identify early trends so these were now completed monthly but a different key area was looked at in-depth. The two monthly internal quality audits were used to assess the quality of care by reviewing care plans and outcomes, medication, control of infection, the environment, catering and user, carer and professional feedback.

These audits were then used to create actions which had allocated owners and timescales for completion to ensure that the home was meeting the required standards of the regulations. An audit completed in December 2015 identified that whilst clear procedures were in place for controlled drugs these needed to be audited regularly by the manager. During the inspection we identified that the manager was auditing the controlled drugs book on a weekly basis to ensure that the stock levels were as described. The last audit had been conducted by the provider in February 2016 and had identified that the relatives meeting had not been booked since the new manager had started at the home. We could see that this meeting had been booked and took place during the inspection at the home. This audit had identified that the chairs in the common areas were 'worn' and 'tatty' as seen during our inspection.

People, their relatives and visitors spoke highly of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home and included the following comments from relatives, 'Thank you all for making the Valentines lunch such a nice occasions, it was a lovely day'…'We would like to say thank you for looking after our (family member)' and 'Thank you so much for looking after (family member) giving him a lovely home and treating him with dignity and respect'. Staff identified what they felt was high quality care and knew the importance of their role to deliver this. Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.