Abbeyfield Society (The)

Victoria House

Inspection report

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Date of inspection visit:
08 January 2019
11 January 2019

Date of publication:
25 February 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 8 and 11 January 2019.

Victoria House Residential Home 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. The home provides accommodation for up to 30 older people some of whom may have dementia. It is located in the Kew area of Richmond in Surrey.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection in November 2017, the key question of well-led was rated requires improvement. The other key questions of safe, effective, caring and responsive were rated good. The overall rating was good. We identified one breach of the regulations regarding the quality assurance system which had not picked up that reviews on the samples of care plans we looked at had not been updated. At this inspection the requirements of this regulation were met.

People said the home had a friendly and relaxed atmosphere with well provided care and support. There were plenty of staff to meet people's needs and they did so in a respectful, kind and compassionate manner.

The home kept thorough, comprehensive and up to date records that were regularly reviewed with information presented in a clear and easy to understand way.

People were encouraged and enabled to discuss health needs and had access to community based health professionals as required as well as the home's care staff. People's diets were balanced, protected them from nutrition and hydration associated risks and also met their likes, dislikes and preferences. Some people said the meals available were of good quality, plentiful and there were sufficient choices provided. Others felt they could be improved. Staff prompted and supported people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy meals.

The home was clean, well-furnished and maintained and provided a safe environment for people to live and staff to work in.

Staff were very knowledgeable about the people they supported and had appropriate skills and training to meet people's needs competently. They provided people with individualised care in a professional, friendly and supportive way.

Staff were aware of their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) require the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider, applications under DoLS had been authorised and the provider was complying with the conditions applied to the authorisation.

Staff said the registered manager and organisation provided good support and there were opportunities for career advancement.

People and their relatives said the registered manager and staff were approachable, responsive and they encouraged feedback.

The home had systems that consistently monitored and assessed the quality of the service provided.

The health care professionals that we contacted were very positive about the care and support provided by the home and raised no concerns regarding its quality.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

'The service remains Good.'

Is the service effective?

Good

'The service remains Good.'

Is the service caring?

Good

'The service remains Good.'

Is the service responsive?

Good

'The service remains Good.'

Is the service well-led?

Good

The service was well led

There was a clear vision and positive culture within the home that was focussed on people as individuals. They were enabled to make decisions in an encouraging and inclusive atmosphere. People were familiar with who the registered manager and staff were and encouraged to put their views forward.

There were robust systems to assess, monitor and improve the quality of the service people received. People and their relatives were involved in these processes and in the development of the service.

Staff were well supported by the registered manager and management team and advancement opportunities were available to them.

Victoria 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 checked 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 inspection and took place on 8 and 11 January 2019.

This inspection was carried out by one inspector over two days.

There were 20 people living at the home. We spoke with seven people, one relative, seven staff, the registered manager and had contact with two healthcare professionals that had knowledge of the home.

We did not use information from the Provider Information Return as one had not been requested. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for six people and four staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their relatives said that the home had a welcoming, relaxed atmosphere and provided a safe place to live. One person told us, "Absolutely fine, well-fed, looked after and safe." Another person said, "I certainly feel safe living here." A relative commented, "Safe and well looked after."

Staff knew how to raise a safeguarding alert and were provided with a handbook containing safeguarding information. There were no current safeguarding alerts. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. Staff were aware of the procedure to follow and agencies to contact to make sure people were safe.

Staff had received policies and procedures regarding protecting people from abuse and harm that their positive care practices reflected. Staff described their understanding of what constituted abuse and the action to take if they encountered it. This matched the provider's policies and procedures. Staff said protecting people from harm and abuse was a very important part of their roles and included in their induction and refresher training.

The home enabled people to enjoy their lives safely, by carrying out risk assessments that included all aspects of people's lives including their health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Staff were trained in personal care risk management and shared relevant information during shift handovers, staff meetings and when risks arose. Risk assessments were also used to learn lessons if something had gone wrong. The home kept accident and incident records that were monitored to identify any trending risk areas. There was a whistle-blowing procedure that staff said they were aware of, understood and prepared to use if necessary.

Staff were aware of de-escalation and trained in techniques in instances where people may display behaviour that others could interpret as challenging. These were focussed on people as individuals and staff had appropriate knowledge to do so successfully. People's care plans recorded any staff actions.

There were thorough building risk assessments that were regularly reviewed and updated. The home's equipment was also regularly checked and serviced. There was a fire evacuation plan.

Staff were available in suitable numbers to make sure that people received the care they required safely and made them feel safe. The number of staff on duty matched the staff rota. This meant the home was able to meet people's needs in a safe, enjoyable and unrushed way. This was demonstrated by people's positive body language and responses to staff. There were a number of staff vacancies that the home was recruiting to.

The home's staff recruitment process was thorough and records demonstrated that it was followed. The process included scenario based interview questions to identify prospective staff's skills and knowledge of their duties and responsibilities. References were taken up and Disclosure and Barring service (DBS) security checks carried out, prior to starting in post. DBS is a criminal record check employers undertake to make

safer recruitment decisions. There was also a three-monthly probationary period with a monthly review meeting. If there were gaps in the knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed. Staff work history and right to be employed were also checked.

Staff were infection control, hand hygiene and food hygiene and handling trained. This was reflected in their working practices. The home carried out infection control checks and regular infection control audits as part of their quality assurance. There was also a plentiful stock of equipment that included gloves and aprons for giving personal care. This helped to minimise the risk of infection.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to up to date guidance. The medicine records for all people were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register recorded the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited monthly. The medicine was safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

The health care professionals we contacted raised no concerns regarding the home providing a safe service for people.

Good

Is the service effective?

Our findings

People were involved in making decisions about the care and support they received and how staff would provide it. Staff were skilled in communicating with people generally including those with dementia. This was done in a way that enabled them to understand and increased the ability of staff to meet people's needs, in a way that was appropriate to them. People and their relatives said that the way staff provided care and support was what was needed and was delivered in a friendly, relaxed, patient and professional way. One person said, "Every effort is made to fix any problems and something is always done." Another person told us, "Pretty good place to be, if you have a problem just say what it is, nobody will bite you."

Staff were provided with induction and annual mandatory training. The induction was thorough, included core training aspects and information about staff roles, responsibilities, the home's expectations of staff and the support they could expect to receive from the provider. All aspects of the service and people were covered and new staff shadowed more experienced staff. This increased their knowledge of the home, people and provided a good standard of quality care. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards'. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Training provided included infection control, safer moving and handling of people, fire awareness and evacuation, emergency first aid at work, food hygiene and health and safety. There was access to specialist services and person specific training including dementia care, managing diabetes and sepsis awareness.

Monthly staff meetings included opportunities to identify further training needs. Quarterly supervision sessions and annual appraisals took place that were used, in part, to identify any gaps in training. There were staff training and development plans in place.

The home carried out assessments of people's needs with them and their relatives and if it was identified that needs could be met, people and their relatives were invited to visit. If a service was commissioned by a local authority or the NHS, assessment information was requested from these organisations or from a care home if they had been transferred.

People could visit the home as many times as they wished before deciding if they wanted to move in and were fully consulted and involved in the decision-making process. The visits were also used to identify if people would fit in with those already living at the home. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person. A lot of people had referred themselves or referrals were made by their families. This was because they had first experienced a short stay at the home prior to moving in permanently or knew other people who lived there.

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.

The MCA and Deprivation of Liberty Safeguards (DoLS) required the provider to submit applications to a 'Supervisory body' for authorisation. Applications had been submitted by the provider and applications under DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves.

Mental capacity was part of the assessment process to help identify if needs could be met. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout our visit.

The home had a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. The records demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams, GPs and district nurses, making referrals when required and sharing information. The registered manager also attended local authority hosted provider forums where information was shared.

People's care plans included areas regarding health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. If required weight charts were kept and staff monitored how much people had to eat and drink. We saw this during meal times with staff frequently encouraging people to keep up their hydration levels. Staff provided nutritional advice.

There was person specific information regarding any support required at meal times, including any possibility of choking and diabetes.

Each person had access to a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. People had annual health checks. People's consent to treatment was regularly monitored by the home and recorded in their care plans. Staff had received training in nutrition, hydration and tissue viability.

The home had seasonal menus that provided a good variety of choice and requests for other meals, not on the menu were met. During our visit staff supported people in a timely way and no one had to wait for their lunch. If needed, staff encouraged people to eat meals. This was done in a patient, courteous and helpful way. They made sure people who needed support and encouragement to eat, received it and this was particularly focussed on anyone with dementia who needed more support to have their needs met. Staff spoke to people at a pace that they understood and repeated information as many times as required so that they could understand what staff were saying and meant. This was done at eye contact level. Staff also used body language that was appropriate and that people positively responded to. People's meal choices were explained and staff revisited them as many times as people required to help them know what they were. They also spent time explaining to people what they were eating during the meal and checked they had enough to eat. This made mealtimes a special and enjoyable experience for people.

Special diets on health, religious, cultural or other grounds were provided. Regular meetings took place between people and catering staff to discuss the quality of the meals, how they were served and choices. The meals we saw were of good quality, looked appetising, smelt nice and were nutritious and hot, although people's comments regarding meals varied from 'excellent' to "The only area that I can think of that requires any improvement." The home was in the process of changing from a contract with a catering firm to employing their own catering staff direct.

The home was clean, well decorated, well-maintained and odour free. The layout was conducive to providing people with a homely atmosphere with suitable communal and personal accommodation. This meant people had the space to socialize as much or as little as they wished.

The health care professionals we contacted raised no concerns regarding the home providing an effective service for people.

Good

Is the service caring?

Our findings

One person said, "It's fun living here. The staff are generally very good." A second person told us, "They [staff] are superb." A further person commented, "Excellent without exception, they always seem to know what we need." Another person said, "Good people work here."

People and their relatives said staff acknowledged them and listened to and valued their views and opinions. They said staff were always friendly, went out of their way to say hello and everyone was treated with respect and patience, in a caring and helpful way.

Staff made great efforts to ensure people's needs were met and this was demonstrated by the way they delivered care and their work ethic. People told us nothing was too much trouble. Staff were aware of the dangers of social isolation and stimulated and encouraged people to have conversations with each other as well as talking to them. They applied their knowledge of people as individuals and recognised their needs and preferences. This enabled people to lead happy, fulfilling and rewarding lives. Staff achieved this individually and as a team. People were treated with kindness and understanding with staff taking a real interest in them, chatting about their respective families and events. The staff approach to care was supported and underpinned by the life history information contained in people's care plans that people, their relatives and staff contributed to and regularly updated.

Staff provided people with care based on treating them with dignity, compassion and respect. They were attentive and responded to people promptly, addressing people by their preferred name, title or nickname. They knocked on people's bedroom doors and waited for a response before entering.

Staff were provided with equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected by staff demonstrating positive care practices and confirmed by people and their relatives. People said staff did not talk down to them and they were treated very respectfully, equally and as equals.

There was an advocacy service available that people had access to if required.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's rights to privacy, dignity and respect that staff followed throughout the home. This was done in a courteous, discreet and respectful way, even when staff were unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

The health care professionals we contacted raised no concerns regarding the home providing a caring

service for people.

Good

Is the service responsive?

Our findings

People said the registered manager, staff and organisation asked for their opinions and suggestions regarding how support was delivered and each aspect of living at the home. They did this formally through meetings and keyworker sessions and informally during casual conversations. People and their relatives were invited to general home meetings and those specific to themselves. The meetings were minuted and people were supported to put their views forward.

Staff made themselves available to people and their visitors if they wished to discuss any problems or if they just wanted a chat. This encouraged people to decide the support they received and staff to deliver support in a way that was appropriate and enjoyable for people. One person said, "There's plenty to do, but I prefer to make my own enjoyment reading and watching television." Another person told us, "Always a lot going on in the building." A relative told us, "The activities are far better than those I experienced elsewhere."

The home provided written information in an easy to understand format. It was in sufficient detail to enable people to understand the type of care and support they could expect and also explained the home's expectations of them.

People were referred privately and by local authorities. Assessment information was provided by local authorities and any available information sought for the private placements from previous placements, GP and hospitals. The registered manager shared this information with appropriate staff to identify if people's needs could initially be met. The home carried out a pre-admission needs assessment with the person and their relatives. People were invited to visit the home before deciding if they wished to move in. These visits were also used to identify if they would fit in with people already living at the home. There was a review of the placement after six weeks.

The home's pre-admission assessment formed the initial basis for people's care plans. The care plans were focussed on people as individuals. They were live documents and contained life history and interests that were added to by people and staff when new information became available. The information gave people and staff the opportunity to identify activities they may wish to do. People's needs were regularly reviewed, re-assessed with them and the care plans updated to meet their changing needs. People agreed goals with their lead staff that were reviewed and daily notes also fed into the care plans. The daily notes confirmed that identified activities had taken place. People were encouraged to take ownership of their care plans and contribute to them as much or as little as they wished. Care plan goals were underpinned by assessments of risk to people.

The home provided a variety of activities based on people's wishes and staff knowledge of people's likes and dislikes. The communal activities were regularly reviewed to make sure they were focussed on what people wanted. There was a sing-a-long session taking place when we arrived on the first inspection day and charades on the second. One person said, "We did exercises this morning." During activity sessions people were encouraged to join in but not pressured to do so. They also interacted with each other as well as staff. We had an open forum discussion with a number of people, in the lounge who put forward and

debated between themselves, what was good about the home and what could be improved. They were quite comfortable doing this when staff were present or not.

A timetable of activities was available that took into account people's interests and ability to participate with staff reminding people of what was taking place each day. The activities co-ordinator facilitated a programme of activities that people had chosen. These included a singing group, cake decoration, exercise, arts and crafts, coffee mornings with raffles, general knowledge quizzes and memory games. The home was introducing sessions with a qualified fitness trainer who specialised in exercise for the elderly. There were also visiting entertainers. A relative told us that they thought people enjoyed the activities provided and they were appropriate.

The home did not directly provide end of life care, rather it provided care and support for as long as people's needs could be met. Staff worked closely with palliative and community nurses, particularly surrounding pain management. There was specific reference to end of life in people's care plans including guidance and people's wishes. When supporting end of life care, the home facilitated relatives to be involved in the care, if they wished during a distressing and sensitive period for them. Staff had received end of life and bereavement training.

People and their relatives told us they were familiar with the complaints procedure and how to use it. The procedure was included in the information provided for them. They told us that generally staff and the management team quickly resolved any issues that people may have, without recourse to the complaints procedure. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and their duty to enable people to make complaints or raise concerns.

The health care professionals we contacted raised no concerns regarding the home providing a responsive service for people.

Good

Is the service well-led?

Our findings

People said the registered manager and management team operated an open-door policy. This meant they felt comfortable in approaching the registered manager as well as staff. One person told us, "The [registered] manager is very good, very efficient." Another person said, "The staff work well as a team." A further person commented, "A pretty well-run place." People's conversation and body language demonstrated that they were comfortable in their relationships with the registered manager and staff.

At the last inspection, we identified one breach of the regulations and made a requirement regarding the quality assurance system as it had not picked up that reviews on the samples of care plans we looked at had not been updated. We followed up the requirement, at this inspection and found it to be met, although one member of staff was struggling with completing the records. This had been picked up by the management team and was being addressed, by supporting the staff member.

The organisation's vision and values made clear what people could expect from it, the home, its staff and the home's expectations of them. Staff said they understood the vision and values and they reflected them in their working practices and positive approach to their roles. Staff said the vision and values were described and explained, to them as part of their induction training and revisited during staff meetings.

Victoria House had very active volunteers whose relatives had previously lived at Victoria House and wished to maintain contact with the people living there and staff. The volunteers ran a fortnightly mobile shop for people. The people living at the home engaged with the local community and had established strong links with a local church and local schools. Staff had received training in activity and community inclusion. The organisation also ran a programme of involving older people as volunteers.

People were very happy to put their views forward formerly as well as on an informal daily basis. There were regular people and relative meetings that staff attended as appropriate so they could address any issues raised. The home also used questionnaires to get feedback from people, their relatives and staff.

The home worked in partnership with other agencies including district nurses, GPs and physiotherapists.

The organisation provided staff with opportunities for personal advancement and to develop knowledge and skills. Staff had personal development plans. There were also a number of staff benefits including an employee assistance programme, season ticket loan and gym membership.

There were clear lines of communication and areas of responsibilities throughout the home and organisation and staff were aware of their areas of responsibilities. They were also aware of the boundaries of acceptable behaviour.

Staff said they were well supported by the registered manager and management team. They thought that the suggestions they made to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member told us, "It's very good working here and I feel

comfortable." Another member of staff told us, "You have to have a heart to work here."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The quality assurance system contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. There were audits, operations managers' monthly visits, pharmacy reviews, weekly and monthly health and safety checks and operational business plans. There were also critical friend visits from other managers within the organisation to quality assure the service, annual policy and procedure reviews and visits from the local authority commissioning and quality teams. A critical friend was someone who provided constructive criticism. Annual policy and procedure reviews were carried out. The organisation was rolling out a new audit tool based on the CQC key lines of enquiry (KLOE) model.

The health care professionals we contacted raised no concerns regarding the home providing a well-led service for people.