Mission Care

Homefield

Inspection report

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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 7, 8 and 10 March 2017.

Homefield is a 44 bedded nursing home situated in the London Borough of Bromley.

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.

In May 2016, the areas of safe, effective and well-led required improvement, caring and responsive were good and there was an overall rating of requires improvement with one breach under effective. At this inspection we found that the breach of the regulation was rectified.

People and their relatives told us that this was a nice place to live and staff provided very good support and care that was delivered in a respectful way. People were given the opportunity to do what they wanted and joined in the activities provided if they wished.

The home's atmosphere was warm, welcoming and inclusive. Visitors during the inspection told us that they were always made very welcome. The home provided a safe environment for people to live and work in, was well maintained and clean. The décor was currently acceptable, although looking a little tired and the home had begun a refurbishment programme with flooring being replaced.

There were thorough up to date records kept, although some historic records required archiving. The care plans contained clearly recorded, fully completed, and regularly reviewed information. This enabled staff to perform their duties appropriately.

The staff knew the people they worked with well including their likes, dislikes, routines and preferences. During our visit people received the same attentive service and everyone was treated equally. Staff had appropriate skills, qualifications and were focussed on providing individualised care and support in a professional, friendly and compassionate way. Whilst professional they were also accessible to people using the service and their relatives. Staff said they had access to good training, support and career advancement.

People were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. They said the choice of meals and quality of the food provided was very good. People were encouraged to discuss health needs with staff and had access to community based health care professionals, if they required them. Two people were however not prompted in a timely manner to eat their lunch or drink.

The home's management team were approachable, responsive, encouraged feedback from people and

consistently monitored and assessed the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us that they felt safe and were well treated. There were effective safeguarding procedures that staff understood, used and assessment of risks to people were in place.

There was evidence the home had improved its practice by learning from incidents that had previously occurred and there were enough staff to meet people's needs.

People's medicine was safely administered; records were completed and up to date. Medicine was regularly audited, safely stored and disposed of.

Is the service effective?

Good

The service was effective.

Staff were well trained.

People's needs were assessed and agreed with them.

Specialist input from community based health services was provided.

Care plans monitored food and fluid intake and balanced diets were provided.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff and people underwent mental capacity assessments and 'Best interests' meetings were arranged if required.

Is the service caring?

Good

The service was caring.

People said they felt valued, respected and were involved in planning and decision making about their care. People's preferences for the way in which they wished to be supported

were clearly recorded.

Staff provided good support, care and encouragement. They listened to, acknowledged and acted upon people's opinions, preferences and choices. People's privacy and dignity was also respected and promoted by staff.

Care was centred on people's individual needs. Staff knew people's background, interests and personal preferences well and understood their cultural needs.

Is the service responsive?

Good

The service was responsive.

People chose and joined in with a range of recreational activities. Their care plans identified the support people needed to be involved in their chosen activities and daily notes confirmed they had taken part.

People told us that any concerns raised were discussed and addressed as a matter of urgency.

Is the service well-led?

Good

The service was well-led.

The service had a positive and enabling staff culture. The manager encouraged people to make decisions and staff to take lead responsibility for specific areas of the running of the service.

Staff said they were well supported by the manager.

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and driving improvement.

Homefield

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 7, 8 and 10 March 2017.

The inspection was carried out by one inspector.

There were 36 people living at the home. We spoke with seven people using the service, eight relatives, 14 staff and the registered manager.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered 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, were shown around the home and checked records, policies and procedures. These included the staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for eight people using the service and eight 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 did not comment whether they felt safe at Homefield. Their relatives said they were confident that the home was safe. One relative said, "I visit every day and am relieved that (person using the service) is in safe hands." Another relative told us, "Having had experience of another home, they (people who use the service) are not left here."

Staff had received safeguarding training, were aware of when a safeguarding alert should be raised and how to do so. Safeguarding information was also provided in the staff handbook. There was one current safeguarding alert that had been raised and referred to the local authority safeguarding team. The home was waiting to hear if the local authority safeguarding team would be pursuing it. They had taken appropriate action in the interim. Previous safeguarding issues were suitably reported, investigated, recorded and learnt from. The home had policies and procedures regarding protecting people from harm and abuse and staff had received training in them. Staff understood what was meant by abuse and the action to take should they encounter it. They said protecting people from harm and abuse was one of the most important things they did and part of their induction and refresher training.

People's care plans contained assessments of risks to them and this enabled them to enjoy their lives in a safe way. Identified risk areas included their health, daily living and social activities. The risks were reviewed and updated if people's needs and interests changed. Staff shared relevant information, including any risks to people during shift handovers, staff meetings and as they occurred. There was also accident and incident records kept and a whistle-blowing procedure that staff were aware of and knew how to use.

There were general risk assessments for the home and equipment used that were reviewed and regularly updated. The home's equipment was regularly checked and serviced. The home and its garden were clean and well maintained, although the décor in the communal areas was looking a little tired. The home had an on-going refurbishment plan that had begun with the replacement of flooring, took into account the least disruption to people whilst this was taking place and that their safety was maintained. New armchairs had also been purchased.

There was a thorough staff recruitment procedure with all stages of the process recorded. Staff recruitment was undertaken by the organisation's HR department. The process included advertising the post, providing an application form, job description and person specification. Prospective staff were short-listed for interview. The interview was conducted by the registered manager and clinical nurses and contained scenario based questions to identify people's communication skills and knowledge of the field in which the home provided a service. References were taken up, Disclosure and Barring Services (DBS) security checks were carried out prior to staff starting in post and there was a three month probationary period. In the case of nurses employed their registration was checked to make sure it was up to date. Work history was checked and an explanation required for any gaps in it. The home had disciplinary policies and procedures that staff confirmed they understood.

During our visit we saw that there was enough staff to meet people's needs and support them to do what

they wanted. This was reflected in the way people did the activities they wished safely. The care workers were attentive, reassuring and took their time to make sure that people were supported safely when moving around the home. One relative told us, "There are always enough staff." The staff rota showed that support was flexible to meet people's needs at all times and there were suitable arrangements for cover in the absence of staff due to annual leave or sickness. This was through the use of bank and agency staff. The registered manager said that whenever possible the same agency staff were used as they were familiar with people using the service, their likes and dislikes and routines.

Medicine was safely administered to people using the service. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records for all people using the service were checked and found to be fully completed 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 records the dispensing of specific controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited monthly. The drugs were safely stored in a locked facility, records of the temperature of fridges where medicine was stored were kept and medicine was appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

At the last inspection on 17 and 18 May 2016, we found a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014 because one person had been assessed by the service as requiring a Deprivation of Liberty Safeguards (DoLS) authorisation, but the manager told us that a DoLS application had not been made. Another person had a condition placed on their DoLS authorisation, requiring the provider to submit quarterly monitoring forms to the authorising local authority that had not been complied with because staff were not aware that the condition was in place. At this inspection we found that improvements had been made and appropriate remedial action had been taken to remove these breaches.

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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider, all applications under the 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. The capacity assessments were carried out by staff that had received appropriate training and recorded in the 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 activities they had chosen throughout our visit.

During our visit people made decisions about their care and what they wanted to do. Staff were aware of people's needs and met them. They provided a comfortable, relaxed atmosphere that people said they enjoyed. Relatives said people were enabled to make their own decisions and that they were fully involved in decisions about the care and support provided. They said the type of care and support provided by staff was what was needed. It was delivered in a friendly, enabling and appropriate way that people liked. One person said, "I love living here." A relative told us, "There's only one place better than here and that's home." Another relative said, "I come every day and you never see people in the same clothes two days running. Everyone is always clean and tidy." Another relative told us, "They (staff) do their very best here, all nice people and I'm very impressed with their patience."

Staff received induction and annual mandatory training. The induction was comprehensive, 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 home. All aspects of the service and people who use it were covered and new staff spent a minimum of three weeks shadowing more experienced staff. This increased their knowledge of the home and people who lived there. The annual training and development plan identified when mandatory training was due. Training encompassed the 'Care Certificate Common Standards' and included infection control, manual handling, medicine, food safety, managing challenging behaviour, equality and diversity and health and safety. This is a set of standards that have been developed for staff to demonstrate that they have gained the knowledge, skills and attitudes needed to provide high quality and compassionate care and support. There was also access to more specialist training to meet people's individual needs, such as dementia, pressure ulcer awareness and end of life care. A member of the home's staff was a dementia champion. Staff meetings included opportunities to identify further training needs. Quarterly supervision sessions and annual appraisals were also partly used to identify further training requirements.

The care plans we looked at included sections for health, nutrition and diet. Full nutritional assessments were done and updated regularly. Where appropriate weight charts were kept and staff monitored how much people had to eat. There was information regarding any support required at meal times. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP as appropriate. Nutritional advice and guidance was provided by staff and there were regular visits by a local authority health team dietician and other health care professionals in the community. People had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

People told us they thought the food was very good with plenty of variety and choice. One person said, "The food is first class." A relative told us, "When (person using the service) first came she had a problem with eating that was quickly sorted out." Staff had received 'Meal times matter' training that focussed on making meals an enjoyable event for people and this was the case for most people we observed. However we observed that for 20 minutes, one person had their meal in front of them without staff noticing it was not touched. This meant it had gone cold. When a staff member did notice and they asked the person if they wanted it, they declined and it was replaced with something more to their liking, which they ate without assistance. Another person had a cup of tea in front of them but did not realise it was there. They asked a staff member when their tea was coming. The staff member then explained to them it was in front of them and helped them to drink it. The body language and speech of neither person indicated that they were distressed by this.

Good

Is the service caring?

Our findings

Staff knew people well, were aware of their needs, preferences and met them. They provided a comfortable, relaxed and enabling atmosphere that people enjoyed. One person told us, "Great staff attitude." A relative said, "The care is second to none, the carers are fantastic, kind and they listen." Another relative told us, "Extraordinary staff so loving and kind." A further relative said, "I'm always impressed with the staff and the way they care for people."

Everyone we spoke with expressed their satisfaction with the home, the staff and their care. People and their relatives said that the staff treated everyone with dignity, respect and enabled them to maintain their independence. The staff met their needs; people enjoyed living at the home and were supported to do the things they wanted to. Staff were friendly, helpful, listened and acted upon people's views and people's opinions were valued. This was demonstrated by a number of positive and supportive care practices we saw during our visit. The staff knew the people they were caring for, called them by their name and interacted with them in a friendly and appropriately familiar way. Staff were able to tell us general things about people, their level of dementia, their engagement and their likes and dislikes. Staff were skilled and patient. They also made the effort and encouraged people to enjoy their lives.

Staff had received training about respecting people's rights, dignity and treating them with respect that underpinned their care practices. The patient approach by staff to providing people with care and support during the inspection meant that people were consulted about what they wanted to do. People were encouraged to join in activities if they wished but not pressurised to do so.

Staff continually made sure people were involved, listened to and encouraged to do things for themselves, where possible. They facilitated good, positive interaction between people using the service and promoted their respect for each other. People were free to move around the home as they pleased.

Staff spoke in a way and at a speed that people could comfortably understand and follow. They were aware of people's individual preferences for using single words, short sentences and gestures to get their meaning across. One person was deaf and staff made the effort to make sure they understood what was being said. Staff spent time engaging with people, talking in a supportive and reassuring way and projecting positive body language that people returned. There were numerous positive interactions between staff and people using the service throughout our visit. One relative said, "Staff interact really well with residents."

The home also had a confidentiality policy and procedure that staff were aware of, understood and followed. Confidentiality was included in induction, on going training and contained in the staff handbook.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. People said they had visitors whenever they wished, and they were always made welcome and treated with courtesy. This was also the case when we visited.

Good

Is the service responsive?

Our findings

People and their relatives said that they were asked for their views and opinions by the home's manager and staff. They were given time to decide the support they wanted, when and where practicable, by whom. It was delivered in a way people liked that was friendly, enabling and appropriate. If there were any problems, they were quickly resolved. People were supported and enabled to enjoy the activities they had chosen. One relative said, "The staff have been dementia care trained and are pretty good. I'm impressed with their patience and attention to detail." Another relative told us, "Staff interact really well with residents and this makes such a difference."

The manager said that before anyone moved in, assessment information would be requested from service commissioners and hospital or a previous care home if they were being transferred. The home carried out its own assessments after people and their relatives were invited to visit, to see if they liked the home. They could visit as many times as they wished so they could decide if they wanted to move in. One person said, "I was shown around and picked my room." The assessments identified if needs could be met and if so people were invited to move in if they wished. People were provided with written information about the home and organisation that outlined what they could expect from the home and what the home's expectations of them and their conduct was.

People's care plans were based on the initial assessment, other information from previous placements and information gathered as staff and the person became more familiar with each other. The home provided care focussed on the individual and we saw staff put into practice training that promoted a person centred approach. People were enabled and encouraged to discuss their choices, and contribute to their care and care plans if they wished. The care plans were developed with them and had been signed by people where practicable. The care plans had goals that were identified and agreed with people. The goals were underpinned by risks assessments and reviewed by care workers and people using the service. If goals were met they were replaced with new ones. The care plans recorded people's interests and the support required for people to follow them. Daily notes identified if chosen activities had taken place. The care plans were live documents that were added to when new information became available. The information gave the home, staff and people using the service the opportunity to identify further things they may wish to do. There was also individual communication plans and guidance.

The activities were a combination of individual, group and mainly home based which was people's preference. The available activities were facilitated by two activities co-ordinators and other members of staff. They included baking, reminiscence, one to one sessions with staff, music therapy and sensory and tactile sessions. The 'Zoo Lab' visited bringing various types of animals and there were also visits from Nightingale dogs. Outings also took place to destinations such as the Mission Café, garden centres and museums. The home had access to the organisation's transport.

People told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. 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. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns. Any concerns or discomfort displayed by people using the service were attended to sensitively during our visit.

Good

Is the service well-led?

Our findings

People and their relatives told us the manager was very approachable and made them feel comfortable. One person said, "The manager walks around speaks to us and really listens." A visitor told us, "You can voice your opinion, I bring up things and they are addressed." They also confirmed that quarterly relatives meetings took place.

During our visit there was an open, listening culture with staff and the manager paying attention to and acting upon people's views and needs. It was clear by people's conversation and body language that they were quite comfortable talking to the manager; equally as they were with the staff team.

The organisation's vision and values were clearly set out. Staff we spoke with understood them and said they were explained during induction training and regularly revisited. The management and staff practices reflected the vision and values as they went about their duties. People were treated equally, with compassion, listened to and staff did not talk to them in a demeaning way.

Staff told us the manager was very supportive. Their suggestions to improve the service were listened to and given serious consideration. There was a whistle-blowing procedure that staff had access to and said they would feel comfortable using. They said they really enjoyed working at the home. A staff member said, "I've been here a long time and really love it." The records we saw demonstrated that regular quarterly staff supervision, staff meetings and annual appraisals took place.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in need and support as required. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that identified how the home was performing, any areas that required improvement and also those where the home was performing well. This enabled any required improvements to be made. Bi-monthly quality monitoring visits were carried out by other manager's in the group that included night visits and there were also quarterly director's visits.

Quality audits took place that included medicine, health and safety, daily checklists of the building, cleaning rotas, infection control checklists and people's care plans. Policies and procedures were audited annually.