

Caring Homes Healthcare Group Limited

Home of Compassion

Inspection report

58 High Street
Thames Ditton
Surrey
KT7 0TT

Tel: 01206224100
Website: www.caringhomes.org

Date of inspection visit:
07 August 2020

Date of publication:
23 September 2020

Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inspected but not rated

Is the service well-led?

Inspected but not rated

Summary of findings

Overall summary

About the service

Home of Compassion is a residential home providing personal and nursing care for up to 78 people in one adapted building. The home supports adults aged 65 and over with a range of physical and mental health needs, including people living with dementia. At the time of our inspection there were 49 people living at Home of compassion.

People's experience of using this service and what we found

Risks to people's safety were not always accurately recorded and monitored. Following accidents and incidents, records were not always completed in detail to ensure lessons were learnt and action was taken. This meant investigating concerns and providing safeguarding information was not always consistent, as well as action to mitigate further risk not always being completed in a timely way.

Since the last inspection a new recording system had been implemented to work alongside their data analyst system. There was improvement required to really embed this in to the way of working to ensure good outcomes for all people living in the home. Examples were seen where on occasions this had been followed and people's care had improved as a result.

Improvements had been made to the overall culture of the service. The registered manager had supported staff throughout the Covid-19 pandemic and staff felt they were able to raise any concerns in regular staff meetings and individual supervision sessions. Staff were aware of their responsibilities in safeguarding people from harm and understood reporting processes and the provider's policies.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 16 April 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This targeted inspection was completed to address specific concerns regarding risks to people's safety and aspects of the management of the service. A full update on breaches of regulations found during our last inspection will be provided following our next fully comprehensive inspection.

We undertook this targeted inspection to check on a specific concern we had about the way risks to people's safety were monitored, how safety incidents were recorded and reported and the management systems in place around this. The overall rating for the service has not changed following this targeted inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned

about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified areas of improvement in relation to action taken as a result of accidents and incidents at this inspection and have made a recommendation.

Follow up

We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Inspected but not rated

Is the service well-led?

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Inspected but not rated

Home of Compassion

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This was a targeted inspection to check on specific concerns we had about how risks to people's safety and well-being were managed and the management systems in place.

Inspection team

The inspection team consisted of three inspectors.

Service and service type

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced. We announced the inspection ten minutes prior to our arrival to discuss the safety of people, staff and inspectors with reference to the Covid 19 pandemic.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included safeguarding concerns and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We sought feedback from professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with five people who used the service and one relative about their experience of the care provided. We spoke with ten members of staff including the area manager, registered manager, assistant manager, senior care workers, care workers and a data analyst.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from relative feedback. We spoke with four professionals, three of whom regularly visited the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check on actions taken in response to lessons learned and whether risks to people's safety and well-being were being managed and reduced where possible.

Learning lessons when things go wrong

At our last inspection we found the provider had failed to ensure lessons were learned from accidents and incidents. A recommendation had been made in relation to this.

- Accident and incident reports had not always been completed in sufficient detail. Since the last inspection an additional "reflective practice form" had been introduced. However, these were not being used for every incident. On ten occasions during June and July the newly introduced form had not been used.
- Actions that had been identified to be completed as a result of a reflective practice form were not always completed in a timely way. We saw examples where an accident or incident had occurred and a review or action had not been completed more than a month later. For example, one person was at risk of falls and identified as at risk of dehydration. An action was set to complete fluid charts at the beginning of June, however, at the beginning of August this still had not been implemented.
- There was a data analysis system that highlighted trends and patterns and documented actions. However, this was not highlighting when actions were not being completed in a timely way.
- There were other examples of where action had been taken in response to an accident or incident with positive results. For example in response to an unwitnessed fall hourly checks on a person were introduced. These were documented on an hourly check record sheet and falls for this person had reduced.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found the provider had failed to ensure that systems and processes were effective in safeguarding people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At this inspection we found that improvements had been made and the registered manager and provider were responding to local authority requests for information. The provider had also taken steps to develop staff practice in this area and staff knowledge had improved.
- People told us they felt safe living at Home of Compassion. One person said, "I feel very safe living here."
- Staff were aware of how to record and report any safeguarding concerns and were knowledgeable in identifying different types of abuse. One staff member said, "If I had a concern then I would tell both the

manager and deputy. I would not be shy in letting them know if something was wrong with a resident. I am aware of the whistle-blowing procedure and I know I can raise a concern if I need to and how to do that. But I have not seen any residents being treated badly."

- Since the last inspection there had been an increase in the reporting of incidents to the local authority safeguarding team, and all relevant, significant incidents had been reported correctly. We will continue to monitor this progress and review the impact of this work during our next inspection.

Staffing and recruitment

- There were sufficient numbers of staff to meet people's needs. Staff did not appear to be rushed when supporting people. One staff member said, "There's enough staff, I'm never stressed."
- A staff dependency tool was used to ensure there were enough staff always at the home to support the people correctly. The registered manager said, "At the moment we have too many staff, but it's nice to be in that position where we can have extra staff on every shift."
- The registered manager followed safe recruitment processes. This included full pre-employment checks, references and a DBS (Disclosure and Barring Service) check. A DBS check confirms if a person is known to police and whether they are safe to work with vulnerable people.

Preventing and controlling infection

- The home was following all Public Health England (PHE) guidance in response to the Covid-19 pandemic. This included staff wearing appropriate PPE (Personal Protective Equipment) at appropriate times.
- Additional cleaning schedules had been introduced which included increased cleaning of regularly touched areas such as handrails, door handles and lift buttons.
- People, staff and visiting professionals had their temperature and oxygen levels checked regularly. Staff told us that they were updated regularly of all changes in guidance and advice.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check on specific concerns we had about how management responded to people and staff when concerns or suggested changes were made and the management systems in place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider had failed to make CQC aware of certain notifiable incidents. A recommendation had been made in relation to this.

- Some people and relatives felt the management of the service had continued to be on occasion defensive and unapproachable. When we raised these issues with the RM and area manager during the inspection, there was a clear plan in place to improve this area so this was no longer the case. During the inspection the management team were open to advice, guidance and best practise. The management responses to any concerns raised on the day had improved since the previous inspection and the registered manager said, "We are striving to make this the best home it can be, we are taking all constructive criticism on board to continue improving."
- Staff told us they were supported by the registered manager. One staff member said, "I am very supported by [registered manager] she is so approachable and been so kind and understanding." Unfortunately there were known tensions between certain members of staff, at this time there appeared to be no impact on the care provided. The area manager said, "It is a work in progress, we are working through the issues within the staffing team and hopefully as a result we will have no issues in the near future."
- Improvement could be seen to the reporting of significant events to both CQC and the local authority safeguarding team. All relevant notifications had been submitted. The area manager confirmed that she was working closely with the local authority to ensure she reported any notifiable events.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection we found that quality checks and leadership were not always robust. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the registered manager and provider were responding to staff and people's feedback

- People and staff told us that they were confident to raise concerns, complaints and suggest changes to the management team. One person said, "I've never needed to complain, if I ever had a problem, I would go to the registered manager."
- Staff meetings had continued throughout the pandemic, in the minutes reviewed there was a good amount of detail, however a lack of actions set. Staff told us that they enjoyed having staff meetings, and the management team would respond to any suggestions made at the meetings.
- In the last inspection it was noted that some feedback had not been responded to with an example of people still not being happy with activities offered. This was difficult to address at this time of a pandemic, however, people told us that they had enjoyed the activities as they had begun to be re-introduced to the home.
- Well-being incentives had continued through the pandemic to ensure staff felt supported through a difficult time. Staff told us, "I have felt very supported recently, especially in relation to the pandemic. The management have been great in not only keeping the people safe but the staff as well."