May Residential Homes Limited

Freshfields Residential Home

Inspection report

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Date of inspection visit:
07 January 2020

Date of publication:
12 February 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Freshfields Residential Home is a residential care home registered to provide personal care, support and accommodation for up to 36 people in one adapted building over three floors. At the time of our inspection the care home accommodated 34 people, many whom were living with dementia.

People's experience of using this service
There were risk assessments in place to monitor risks to people. However, these were not always holistic. Recruitment procedures at the service were not always robust, there were gaps in people's employment histories which were not explained. People were not supported to have maximum choice and control in their lives and staff did not support them in the least restrictive way possible. The policies and systems in the service did not support this practice. Mental capacity assessment forms were not always completed with people. There were no consent to care forms, although people told us, and observations confirmed that staff always sought consent. Some staff had not completed their mandatory training. The provider gave us assurances this training would be completed in the months following our inspection. People's information was not always kept securely. Quality assurance processes did not identify the issues we found at inspection.

The service decoration was not dementia friendly and we have made a recommendation about this.

Although some people had mixed views about staff numbers, the management team were able to demonstrate with dependency tools and rotas there were enough staff to meet people's needs. Staff understood people can be at risk of abuse and knew who to report it to if they suspected it. There were infection control measures in place and staff understood infection prevention. Medicines were managed safely. Lessons were learned when things went wrong.

People's needs were assessed before using the service to ensure they could be met. Staff received an induction before starting employment. Staff received supervision and appraisals. People were supported with their healthcare needs and the service worked with other agencies to the benefit of people. People mostly enjoyed the food they were provided and were supported to eat and drink healthily.

People and their relatives told us they were treated well. Staff understood equality and diversity. People could express their views and be involved with choices around their care and treatment. People told us their dignity was respected and their independence promoted.

People's needs and preferences were recorded in care plans. The service provided activities for people. The service made information accessible to people with communication needs. People were able to make complaints and when doing so these were responded to appropriately. The service worked with people who were at the end of their lives and recorded their wishes before this occurred.

People told us they thought highly of the management team. The management team were responsive to inspection findings and wanted to improve the service to the benefit of people who lived there. People and staff held meetings and were engaged with the service. People and staff were able to complete surveys to assist with improving the service. The service had a presence within the local community.

Rating at last inspection
The last rating for this service was Good (published 14 July 2017.)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to good governance and people providing consent. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Freshfields Residential Home

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

Inspection team
The inspection was carried out by one inspector, one inspection manager and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection manager was observing the inspector as part of Care Quality Commission's quality assurance processes. They also assisted with the inspection.

Service and service type
Freshfields 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 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 unannounced and took place on 07 January 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eleven people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff; one of the directors, the registered manager, four care staff and the chef. 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.

We reviewed a range of records. This included three people's care records and multiple medicine records. We looked at four 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 the provider to validate evidence found with specific regard to training and seeking consent.

Requires Improvement

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 good. At this inspection this key question had deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks to people were recorded and monitored. There were risk assessments in place to monitor aspects of people's health, their safety and their wellbeing. Risk assessments covered falls, nutrition, depression, moving and handling and numerous other areas that assisted staff with monitoring people's health and wellbeing. However, we found risk assessments where in place did not always take into account factors that could increase or decrease risk. For example, we looked at one person's falls risk assessment and we saw that it did not consider the person's medical conditions. This person's medical conditions affected their mobility and stability and therefore should have been taken into account.

● We spoke with the registered manager and director about our concerns and they were responsive to our feedback. They explained they would make changes to the falls risk assessment we highlighted and that they were hoping to implement an electronic care planning system that would incorporate risk assessments. They were unable to tell us when this would be implemented though.

Staffing and recruitment

● Recruitment practices at the service were not always robust. We looked at four staff files and saw that they contained references from previous employers, application forms, employment histories and enhanced Disclosure and Barring Service (DBS) checks. Employers complete DBS checks to see if staff have any criminal convictions or if they are on any list that bars them from working with vulnerable adults. However, the service had no record explaining gaps in people's employment histories and there were no risk assessments or mitigating actions recorded when staff had health conditions or positive DBS checks. This meant people were potentially put at risk because systems were not in place to support staff in their roles and people may also have been put at risk of being cared for by staff who were unsuitable for a caring role.

● People had mixed views about whether there were enough staff to meet their needs. One person said, "No, I think they could do with some more [staff]" Another person said, "Yes, I think so [there are enough staff]." Observations and records indicated there were sufficient staff to meet people's needs, and we noted arrangements with an agency which meant if regular staff were unable to work there was a fall-back solution. The provider showed us they used a recognised dependency tool to work out how many care hours they needed to provide to meet the needs of people using the service.

● The service also monitored and checked for risks regarding environmental factors in the home such as fire safety and building and appliance effectiveness and safety. They did so through regular monitoring checks and had robust plans in place to ensure that people were kept safe in the event of emergency. We highlighted a potentially out of date fire risk assessment and following the inspection the director sent us evidence they had arranged for a specialist service to come and assess the service again.

Systems and processes to safeguard people from the risk of abuse

● The service sought to safeguard people from the risk of abuse. One staff member said, "Safeguard the residents from anything, harm or abuse. Financial, physical, emotional." Staff told us they would report abuse should they suspect it and they were supported in this by the service's policies and procedures.

● Some people agreed for their money to be looked after by the service. Systems were in place to ensure people were not at risk of financial abuse. We counted five people's money and looked at the documentation associated with its safekeeping and found it all to be in order.

Using medicines safely

● Medicines were managed safely. One person told us, "About 7am I get a cup of tea and a biscuit with my medication and a kind word." Staff, who were trained, administered medicines and their competency to do so was checked regularly. We observed people administering medicines counted people's medicines and checked how this was recorded and found everything in order. Medicines were audited regularly. There were policies and procedures in place to guide staff on what to do.

Preventing and controlling infection

● Staff understood the importance of infection prevention and control. One staff member said, "Wear gloves and aprons, sacks for soiled padding, we have clinical waste outside the building." Staff had been trained in infection control and were also competency checked with regards to their knowledge in this area.

● The service kept cleaning schedules and records to monitor the cleanliness of the home. All people and relatives we spoke with thought the home was kept clean and tidy.

Learning lessons when things go wrong

● Lessons were learned when things went wrong. We saw incidents and accidents were recorded and where improvements could be made, or lessons learned, measures were put in place to prevent their reoccurrence. For example, we saw an incident report where person had a fall and following this they were monitored more regularly to decrease the likelihood of it happening again.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Mental capacity assessments were not always completed. We were informed by the management team that half the people using the service had dementia, a progressive syndrome that affects brain function and people's capacity to make decisions. However, we saw care plans where people were diagnosed with having dementia but did not contain mental capacity assessments. This meant it was unclear whether the service was always meeting their needs or acting in their best interests.
- One mental capacity assessment we looked at had not been properly completed, with questions asked not being responded to by the staff member completing the form. This again meant it was unclear whether the person's needs were being properly met or the service was acting in their best interests.
- There were no consent to care forms. Whilst we agreed with the provider it is fair to assume consent can be implied, particularly where people have signed their agreement with other documentation, it is best practice to ensure that people's consent to care is recorded. The provider's policies highlighted as much and said that "Residents (or their representative) are always asked to sign their plan of care." We saw that some care plans were signed, but not in all the places where changes had been made, which would indicate people's agreement.
- We were told the service had made only three DoLS applications. Given the lack of completed capacity assessments and the amount of people living at the home diagnosed with dementia, it is possible more applications for people to be assessed for DoLS need to be made.

The provider had not made sure care and treatment of service users was provided with consent of the relevant person. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We spoke with the director and registered manager about our concerns and they highlighted they are seeking to change care plans and in doing so would seek to do more capacity assessments, which in turn might lead to further DoLS applications. They would also ensure that consent to care is explicit. Following the inspection, they sent us updated templates of their mental capacity assessments and consent to care agreements.

● People told us, and observations indicated, that consent from people was sought when staff provided care. One person told us when specifically asked about staff seeking consent said, "I think they are good in that way."

Adapting service, design, decoration to meet people's needs
● The service had been adapted to meet people's needs. There were lifts for people to use and handrails throughout the service. Each person had their own room and most rooms had their own en-suite bathroom. People could decorate their rooms how they pleased and the provider told us they sought people's opinion when making changes to decorations. However, we felt the service could be made more dementia friendly. Changes to carpets, zoning of areas and handrails with colour coding, improved signage and personalisation of peoples' room doors could all enhance the environment for people with dementia. We discussed this with the provider and they told us they would discuss this further with people using the service and investigate how to improve.

We made a recommendation that the provider seek best practice guidance with respect to making the service more dementia friendly.

Staff support: induction, training, skills and experience
● Records showed that some staff had not completed training that the provider considered mandatory. For example, eight care staff had not had infection control training. We raised this with the director following our inspection and they provided us with evidence training sessions had been arranged for staff who had not completed their mandatory training. Whilst we found these concerns with training completion, people told us that staff were appropriately skilled to do their jobs. One person said, "I think they are wonderfully trained."
● All staff received an induction when they started work. This was so they knew what to do when they began working with people. Induction included training, shadowing experienced staff and meeting people who lived at the service. Staff induction records were signed off by management to indicate staff were competent to start work. New employees who were new to care were also offered the opportunity to complete the Care Certificate, a recognised foundation course in the basic aspects of care.
● Staff received supervisions and appraisals. One staff member told us, "[I have] one supervision every three to four months. I can talk about anything." Supervision provided a platform for staff to discuss issues they had, development they wanted and receive updates about the service and provider. This meant people were cared for by staff who were supported by the provider.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they started using the service. Assessments followed best practice guidance and recorded people's ongoing physical and mental health needs and provided the service with the opportunity to assess whether they could meet those needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported with their health care needs and the service worked well with other professionals.

One person said, "We have a very good GP who visits and sits in our rooms and the dining room." People's care plans contained records of communications with agencies involved in their care. We saw correspondence with other agencies, such as GPs, nutritionists, dieticians, cardiologists. district nurses as well as solicitors and independent advocates, that demonstrated they all worked together to ensure people's care was led in a person-centred manner.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink and maintain a balanced diet. Whilst there were mixed opinions about the standard of the food, they were generally positive. One person said, "The weekends are not as good as Monday to Friday. The food is too salty." Whilst another said, "It is lovely. The two ladies in the kitchen are wonderful. Always asking what you like. If you don't like something they are always doing their best to help you." We observed staff helping people during lunch and being attentive to their needs whilst they were dining. Residents meetings provided an opportunity to feedback about the food and input into the menu.

● The kitchen was well maintained, with health and safety measures in place for the storage and distribution of both cooked and cold foods.

● People with special diets had their needs catered for. One relative said, "They know [person] is diabetic and gets special food. They don't get a sweet like the others do, but something else." We saw that some people had specialist food needs. All food requirements were recorded in the kitchen and in people's care plans. There was communication with dieticians and speech and language therapists as and when necessary.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● People's private information wasn't always kept securely. People's care plans were kept in a locked cupboard but keys for the cupboard were accessible for anyone walking past, which could include visitors to the service. We also noted that some people's information was written up on a board where visitors could see it. We found monitoring folders were left out in the dining room where visitors could have access to them and we also saw medical folders were temporarily left out in a public walk way where anyone passing by could read them.

People's information had not been maintained securely. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back to the management team about our concerns and they said they would make changes to ensure these potential breaches of confidentiality would not occur again.

● Although we found concerns with how people's information was stored, staff understood confidentiality and keeping people's information private. One staff member said, "We don't gossip about people…We wouldn't give information over the phone."

● People's privacy and dignity was respected by staff. One person said, "I would say yes [they respect my privacy]. They always knock on the door." We observed staff knocking on people's doors. A staff member confirmed that people's privacy and dignity was respected, "Make sure you introduce yourself. [People] will tell you [what they want], but you ask, always tell them what you are going to do before you do it. We can guide it. Also blinds down, door locked." Every person had their own room and were able to spend time in their rooms when they wanted and were supported to use their own bathrooms.

● Staff promoted people's independence. Staff encouraged people to do as much as they can. One staff member said, "[For example], help them choose their own clothes." We observed staff assisting people at lunch time and saw people were encouraged to do what they could. Documentation at the service also sought to promote independence. For example, the service had a statement of purpose which highlighted the importance of people's independence, how the service sought to maximise people's possibilities, "encouraging residents to have access to care."

Ensuring people are well treated and supported; equality and diversity

● People told us staff were kind and caring. One person said, "Yes and I think they are kind to everyone." We observed staff working with people and saw that they were caring and thoughtful. We saw people smiling

when staff worked with them and staff appeared unhurried in the tasks they completed with people.
● The service and staff had received numerous compliments about their care. These were often written in thank you cards. One we read said, "It was lovely that we could be with [person] in a lovely homely surrounding." Another read, "A big thank you for to everyone looking after [person] so well." This showed that people and their relatives thought people were well treated.
● The service sought to support people with faith beliefs. One person said, "Oh yeah they come every week with communion." Another person of a different faith denomination added, "Yes, they come and visit me. Also, I can listen to the congregation on my [tablet], which is comforting." Staff told us the care they provided was personalised and supported people to be themselves as individuals. One staff member said, "We treat them all as individuals." This approach ensured equality and diversity were underpinned by the services policies and documentation.

Supporting people to express their views and be involved in making decisions about their care
● People were able to express their views and were involved in decisions about their care. One person said, "Oh yes [I'm involved]." Their relative said, "Also must add [staff member] put off the review for the care plans until I could make it so [family member] and I were involved." Meetings were held with people where care plans which recorded people choices about their care were reviewed regularly.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's needs were recorded in their care plans. Care plans contained information about what people needed, what they liked or disliked and their risks. This meant care plans were personalised. We saw care plans focused on people's personal care, their mobility, their medicines and their nutrition as well as numerous other topics that were important to people's care. Care plans were reviewed regularly by staff with people's involvement.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The service provided activities for people. One person said, "Oh yes they do outings occasionally." We heard and observed staff providing activities with people. People were smiling and appeared interested during a quiz we saw being run by a dedicated activities coordinator. We saw evidence of day trips for people and were also told by people about visitors who interested them culturally, such as people from faith denominations and entertainers.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The service assessed and recorded people's communication needs and worked with other health and social care professionals to ensure they could meet those needs. Staff knew who had communication needs and worked with them in ways how they wished. Staff told us they used signs and tools to assist communication with people. On staff member said," We've got pictorial menu," which they told us helped people with communication needs choose their food. We also saw a pain assessment chart which was pictorial and questionnaires that had text enlarged for the visually impaired. This meant the service sought to meet people's communication needs.

Improving care quality in response to complaints or concerns

● People knew how to make complaints and told us they would be happy to do so. One person said, I would speak to whoever was in charge that day or I would speak to [registered manager] or [deputy manager]." A relative said, "I would see the head person here. So far nothing to complain about." We saw records of complaints and saw that the registered manager or director had responded to them appropriately according to the service's complaints procedure.

End of life care and support

● People received appropriate end of life care. Staff told us, and records confirmed, they received training and understood what good end of life care was. One staff member said, "Yes make sure people are comfortable and pain free." People had end of life care plans where their wishes were recorded. The service worked with other agencies to ensure people were supported at their time of death.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● Quality assurance processes failed to identify issues we found at inspection; risk assessments not being holistic, gaps in people's employment, issues with consent, mental capacity and confidentiality.

Systems and processes did not always assess, monitor and improve the quality and safety of service users nor did they support the confidentiality of people using the service. This meant people's privacy, health and safety were all at risk. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw that audits were completed on a regular basis. These audits covered health and safety, falls and medicines administration.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● Management at the service were open and transparent throughout the inspection. It was apparent whilst disappointed with our findings at inspection, they wanted to continuously learn and improve the care they provided and began making changes before the inspection was completed.
● Staff and management understood their roles, the risks to people and the service and their regulatory requirements. Management would investigate complaints and incidents, and where necessary inform and apologise family members if and when things went wrong. Management would also inform the local authority and the Care Quality Commission when they were required to do so.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● People told us they thought highly about the service and staff. One person said, "It is very good. It was my choice and I was told it was a very good home." A relative said, "I don't think you can fault it. It is excellent. Let's say if I ever had to have care I hope I can come here." Observations at the home indicated staff and management promoted person centred care and sought to ensure people were comfortable and cared for in manner which they liked.
● Staff thought highly of the management and their approach to staff. One staff member said, "[Registered manager is] great. Superb." Another staff member added, "[Management have an] open door policy and are

fair. [Registered manager] always acts on things." Staff understood the need to provide high quality person-centred care. The service had a service user guide and policies that outlined the person-centred values of the service.

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

● People told us they held resident's meetings. One relative said, "'My [family member] gets a print out of the minutes." Records of resident's meetings noted people were informed about the changes at the service and were able to provide input in to what was happening. We saw discussions focused on food, activities and housekeeping.

● People, relatives and staff engaged with the service through surveys. All surveys we read were positive. One staff survey read, "Satisfied and supported," whilst a survey completed by a person said, "Staff are very kind and caring and always willing." Management explained if shortfalls in service were identified, actions were completed to address them.

● Staff told us they attended meetings. One staff member said, "We discuss everything. Management and the staff. Any issues." Records of meetings indicated discussions included people's care and wellbeing and changes to the service.

Working in partnership with others

● The service worked well with other agencies to provide care and treatment and ensure the service had a local community profile. People of faith, volunteers and local schools all came to visit people using the service. The registered manager attended providers meeting run by the local authority, as well as being involved with other services and organisations that might benefit the care people at the home received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Service user's information was not always kept securely. Risk assessments were not always holistic. People's consent was not always sought. There were gaps found in staff employment histories. Quality assurance processes failed to identify shortfalls within the service.