HC-One Limited

Holywell Dene Care Home

Inspection report

Holywell Dene Road
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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

Overall summary

Holywell Dene Care Home is a care home providing care to a maximum of 48 older people, some of whom have needs associated with dementia. 39 people were living at the service at the time of our visits. One person had been admitted for short term care. Nursing care is not provided. The accommodation is provided across three floors. The home had a registered manager who was on long term leave at the time of the inspection. A temporary manager was in charge of the home.

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 2008 and associated Regulations about how the service is run.

This inspection took place on 19, 20 and 26 November 2014 and was unannounced. There were 39 people living at the service at the time of our inspection. People's accommodation was spread across three floors. Kitchen

Summary of findings

and laundry services were located in the basement level. The service provided care to older people, some of whom were living with dementia. People living with dementia were accommodated on all three floors.

We last inspected Holywell Dene Care Home on 28 October 2013. At this inspection we found the service was meeting all the essential standards we assessed.

We found people were safe at the service. The building was clean and well maintained, no trip hazards were noted, risks were assessed and staff were trained in safety, emergency and safeguarding procedures. The service had sufficient staff on duty. Staff recruitment, staff disciplinary processes and the arrangements for managing medicines ensured, as far as possible, people were protected from harm.

People told us that they, and their families, had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. We found people's support was provided as detailed in their care plans and people's needs had been thoroughly assessed. This meant people receive support in the way they needed it.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. Most people were supported to maintain their independence and control over their lives but one person commented that their independence was restricted due to the security of the building. This was because they felt capable of going in the garden themselves but needed staff to operate the security key pad.

People were treated with kindness and respect. They were afforded choices with regard to activities and getting out and about, though we found the menus rather restrictive. Arrangements for special diets, support with eating and presentation of food were satisfactory.

The provider monitored the service well through a combination of audits carried out by the staff at the service, quality assurance visits by the provider's representatives, gathering of data from the service and use of surveys. We received positive comments about the temporary manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of the risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken, in response to allegations, to maintain the safety of people who used the service.

There were appropriate staffing levels to meet the needs of people who used the service.

Good

Is the service effective?
The service was effective.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink according to their plan of care but some people found their choice was restricted

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required if they had concerns about a person's health.

Good

Is the service caring?
The service was caring.

People who used the service told us they were respected by the staff.

Staff were respectful of people's privacy.

People or people's representatives were involved in making decisions about their care and the support they received.

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Good

Is the service responsive?
The service was responsive. From our observations and talking with people who use the service, staff and visitors, we found that most people made choices about their lives in the home and were provided with a range of activities.

People's needs had been thoroughly and appropriately assessed and people's support was provided as agreed in their care plans.

There was a good system to receive and handle complaints or concerns.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led. There were systems to assess the quality of the service provided in the home and we found that these were effective.

The service had an absent registered manager and a temporary manager was managing the home. The staff were supported and there were good systems in place for staff to discuss their practice.

People who lived in the home and their relatives were asked for their opinions of the service and their comments were acted on.

Holywell Dene Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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 inspection took place on 19, 20 and 26 November 2014 and was unannounced.

Our first visit was unannounced and the inspection team consisted of an inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

On the first day of our visit we focused on speaking with people who lived in the home and their visitors, speaking with staff and observing how people were cared for. The inspector returned to the home on subsequent days to look in more detail at some areas and to examine three individual staff records and records related to the running of the service.

During our inspection we spoke with six people who lived in the home, four visitors, three senior care staff, three care staff, two ancillary staff and the temporary manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We also looked at records that related to how the home was managed.

We observed care and support in communal areas, spoke to people in private, and looked at care and management records.

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

Before and during our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. And we contacted local commissioners of the service, GPs, district nursing teams and the challenging behaviour team who supported some people who lived at the service to obtain their views about it.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel very secure and always safe here." One visiting professional commented on this to us, saying "My client was very safe but it did not suit her as she needed to be able to get outside more and the garden was not safe. But the service were very imaginative in ways they could compensate, they took her out a lot." The temporary manager explained that the fence around the garden had recently been replaced so it was safer for people to access independently.

Our contact in the contracts department at the local authority that commissioned the service told us they were concerned about the number of safeguarding matters that had been referred to them. An officer from the local safeguarding team told us they had recently been working with the home and had provided some staff training.

We saw the home had clear, accessible written policies and procedures concerning safeguarding vulnerable adults and whistleblowing. The temporary manager told us that since coming to the home she had expected staff to familiarise themselves with these and we saw these had been signed off as read by most of the staff team. There was evidence that, in response to safeguarding allegations, steps had been taken to make people safe in the short term and, where necessary, staff disciplinary procedures were invoked and seen through. Staff confirmed they were trained in and understood safeguarding procedures. One staff member told us that she had raised concerns in the past and her concerns had been addressed, she would not hesitate to do so again should the need arise. This demonstrated that the service took these matters seriously and endeavoured to keep people safe from harm.

We saw that people's care files contained risk assessments and plans for managing risk, such as moving and handling risks. We also saw risk assessments had been carried out for the safety of the premises, use of equipment and handling of substances. For example, an up to date fire risk assessment and risk assessments related to infection control were in place.

Staff reassured us that they clearly understood emergency procedures were in place. For example, we saw the service had a number of emergency and contingency arrangements, such as loss of services, which included flow charts for staff to follow and the emergency contacts' telephone numbers.

We saw the premises were well presented and no safety hazards were noted, apart from four of the bedroom radiators on the first floor were not working. We saw temporary radiators were being used. We were told this matter had been reported and later the temporary manager confirmed an engineer had visited and the radiators were operating properly. The building was well lit, with hand rails in all areas. Each entrance to stairwells and lifts had a numeric keypad ensuring all doors remained locked.

We saw the home employed a handyman who carried out and recorded routine safety checks of the building at frequencies set out by the provider. For example, fire safety and water temperature checks. These were up to date and signed off by the 'handyman'. Up to date certificates for safety were available for the gas and electrical installations.

The above showed the provider endeavoured to provide care safely and in a safe environment.

The three staff recruitment files we looked at showed the provider had a safe process that protected people from unsuitable staff by making the appropriate checks before employing someone. For example, we saw employment histories were required, references were taken from previous employers and checks were carried out with the Disclosure and Barring Service (DBS).

The service employed 41 staff in total, 29 of which were part time. We were told that agency staff were not being used. Staffing levels were appropriate for the number and dependency of people using the service. Rotas showed that the staffing levels we saw at our visits; one deputy, two seniors and seven care staff were routinely provided, supported by two housekeeping staff and two kitchen staff. Two care staff were deployed to each floor. We noted that laundry staff were not employed and the housekeeping staff confirmed their duties included laundry tasks. They told us this was manageable. The home was clean throughout and there was no build-up of laundry when we visited the laundry room. We saw staff carried out their tasks in an unhurried manner and people's calls were answered without undue delay, though call buttons were not easily reachable in some areas. There was one period

Good

Is the service safe?

of the day when one of the lounges was not supervised by a staff member. We saw one person in this lounge was unsteady on waking and standing upright. We saw that staff noted this in passing and came in to the lounge to wake the person and assisted them. We made the manager aware of this who undertook to review people's needs in regard to assistance and supervision.

This demonstrated that the provider ensured, as far as possible, that staffing arrangements protected people from harm.

We observed medicines being given to people on all three floors of the home. We saw this was done safely and storage arrangements were satisfactory. These procedures together with medicines administration records showed that people received medicines as they should.

Good

Is the service effective?

Our findings

One relative told us "My wife is very well cared for here, her room is very good, and the food is excellent'. In our discussions with staff they demonstrated an understanding of people's needs and how to deliver appropriate care.

The staff told us and records confirmed they underwent a thorough induction training when they first began work. The staff induction work folder showed the provider ensured each staff member was comprehensively trained to the same level of knowledge and skill in subjects such as; health and safety, food hygiene, moving and handling and safeguarding . The staff training matrix showed that the majority of staff, including bank staff, had undertaken on-going training in these and more advanced and special subjects, such as falls awareness, promoting healthy skin and person-centred care. Other specialist training was also being undertaken, such as end of life care and parkinson's disease. The provider promoted good care for people living with dementia through their 'Open Hearts and Minds' module training which included; creating therapeutic relationships and understanding and resolving behaviours that challenge. Staff made the following comments about training; "The induction was very good and I was shadowing other staff for two weeks, so I was well prepared." "I have had all sorts of training and it is all up to date. I enjoy it."

The manager told us that staff underwent a six month probation period, during which they had a staff mentor and after which their first supervision meeting was conducted. Supervision sessions are used to review staff performance, provide guidance and to discuss their training needs. Staff confirmed this and told us that they received regular on-going supervision meetings and annual appraisals. The records of these showed that all staff had received an annual appraisal in 2014, apart from those who were still in their probationary period, and regular supervision throughout the year. We saw that action plans resulted from both of these processes and these included training opportunities. This demonstrated that the provider ensured, as far as possible, that staff were enabled to deliver care to a safe and appropriate standard.

We saw that 92% of staff had received training in The Mental Capacity Act. Staff demonstrated an understanding of people's rights to make decisions and were able, in their discussions with us, to describe how capacity could be assessed and what action they may take if people were not able to make important decisions. For example, one staff member told us, "We judge if people have capacity by talking to them, getting to know them and if we think they may not have capacity to make a decision we would need to involve other people to make the decision, families for example, or other professionals who know the person." We saw evidence of this in one person's care records where a professional from the local challenging behaviour team had been involved in carrying out an assessment of the person's capacity to refuse care.

We saw in records that four people, who did not have capacity to make decisions, had appropriate arrangements in place to protect their rights. For example, one person had a Court of Protection appointed deputy to act on their behalf in decision making.

We saw in care files that people's consent was obtained for treatment. For example, people had signed their consent forms for the flu vaccine. We also saw that staff asked people for their consent to receive day to day support. For example, two staff asked permission before helping a person to move to the dining room.

The Care Quality Commission (CQC) monitors the application of the Mental Capacity Act 2005 (MCA) and the operation of Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS is a legal process used to ensure that no one has their freedom restricted without good cause or proper assessment. The temporary manager had made contact with the local supervising authorities regarding making referrals. A special assessment was used to help staff identify those people who may require a referral and one urgent application had been made earlier in 2014. This had been followed up with a request for an extension and a standard authorisation, in accordance with legal processes. CQC had been notified of this.

We talked with people and the staff about the food and drink. Most people said the food was good, but one person said, "It varies a bit from time to time, most of the time it is ok." We observed two mealtimes and saw the staff were aware of individual people's needs, and helped those who needed assistance with their meal. We saw in care records that there was a nutrition profile for each person living at the home, which included their preferences and any special needs. Jugs of juice were available around the home and we saw people being offered these in some lounges but not in others. We noted that drinks were not

Good

Is the service effective?

offered until after the meal at one mealtime we observed, although they were available. Food was available between meals, for example homemade cakes were served with afternoon drinks. Some people required their food and/or fluid intake to be monitored and we saw this was clearly recorded including the amounts taken.

One person told us there was no choice of food. At the meal we observed there did not appear to be any choice offered to people as each person was given a roast pork dinner. We looked at the menus and talked to the cook who confirmed that the menus were issued by the provider. We were told this was because the provider employed a central team for catering who devised all the menus on the basis of balanced nutritional content. However, it meant that there was no second alternative choice on the menu at mealtimes. The cook said she would prepare an alternative if requested and could 'tweak' the menu according to what she knew people liked or disliked. She also showed us that she had a list of people's dislikes and allergies. At another mealtime we saw staff discuss with a person, who left their meal, whether they would like an alternative and saw that the staff requested a different meal from the kitchen. Although people were not making active choices at mealtimes the staff ensured people received food they wanted to eat.

The service provided care to older people, some of whom were living with dementia. People with dementia were accommodated on all three floors. We talked to the manager about how well this worked and they commented that they found it was beneficial for people with dementia to be with people who were able to communicate and were more independent as it made for a more stimulating atmosphere.

We saw each floor was accessible only by means of numbered security key pads. There was some evidence that one person found this overly restrictive and intrusive. For example, one person told us that it meant she could not go out to the garden easily as she would like to and had to rely on staff to let her out. We shared this with the manager who said she would look into this arrangement. We noted that the same person became very annoyed when another person wandered in to their bedroom uninvited. We saw all other people on each floor walked about the service safely, freely and with no apparent distress to themselves or others.

We saw referrals had been made to health care professionals where necessary, for example GPs, dieticians and speech and language therapists. There was a section in the care records for staff to record conversations they had with visiting professionals. A relative told us that the staff always contacted the GP when necessary and made sure appropriate equipment was obtained when necessary.

Good

Is the service caring?

Our findings

A visiting relative told us, “The staff are very caring, they go above and beyond.” Another relative told us, “Mum is so much better since she came here, she has put on weight, she is happy, they are so good here, and I have no problems whatsoever.” We saw a collection of thank you cards in the office, all of which included positive comments about the care. The following is an extract from a written comment; “There is an obvious love for old people and the obvious need to make sure that they are happy, comfortable and secure. I have been overwhelmed by the dedication to my mum and also the other residents.”

We saw staff approached people in a caring and kindly manner. The home had a calm atmosphere and people were on the whole very settled. There was a relaxed and comfortable feeling during the lunch time. We saw people could come and go from their rooms, as they wished, and when they were required to move to other activities their permission was sought first.

Staff told us they received training in dignity and respect. One staff member said, “We get a lot of training around caring, respect and dignity and diversity.” We saw the provider had issued posters, displayed in the office, concerning respect and dignity. We saw people’s privacy was respected. Staff spoke quietly to people when talking with them about their care and knocked on people’s bedroom doors before entering. One visitor told us that since she started visiting the home she had become friends with other people and staff and the home had a good feel to it.

The caring approach of staff when they were assisting people was noted by us. For example, they described in detail to the person what they needed to do and how they would go about it. This resulted in a calm unstressful transfer, using complex equipment, from one sitting position to another. This caring approach was commented on by a relative. She told us she was very happy with her mother’s care, confirmed she was involved and was contacted each time the staff had any concerns.

For people whose GP did not visit weekly the records showed that the service would call for a GP consultation as they required it.

Staff respected people’s individuality and independence. We noted that staff used people’s names when addressing them and a member of staff greeted one person, who had decided to get up late, with an affectionate “Good morning (name). Have you enjoyed that lie in?” The person responded in the same manner and a very good humoured and respectful conversation ensued. The staff member enquired whether the person wanted any help making their way to the dining room and when the person said “No, I will manage with the handrail, I will get there.” the staff respected this.

The senior staff demonstrated that they could adapt their style of communication to people’s needs. For example, we saw the staff responded reassuringly to help calm or distract people. They spent quality time with residents talking to them and reassuring them. They all appeared to know and understand each individual resident’s needs. Staff told us that two people with dementia needs had developed a firm friendship. We noted during our SOFI observations that the same two people spent almost an hour sitting together in the lounge, handling, sharing and talking about a doll which had been left on the window ledge near to their seats. Both people appeared to derive pleasure and comfort from this activity.

Good

Is the service responsive?

Our findings

The records showed and people confirmed their needs were assessed, where possible, before coming to live at the home. For example, we spoke with a relative who was visiting her mother who explained that she had been in the home a few months. Before her relative moved in, the manager came to her house and discussed her mother's needs and a care plan. We saw pre admission assessments in people's care files. In one record, for a person who was admitted as an emergency, we saw an assessment had been carried out on the day the person was admitted with a seven day temporary care plans put in place immediately. These had been reviewed and updated as required after the seven day period.

For people who had planned admissions to the home the six files we looked at contained assessments of needs, risks and care plans to address people's needs. Specialised risk assessments were used for nutrition, healthy skin and falls. Where risks were identified care plans had been put in place to manage these. For example, we saw one person had been referred to the dietetics service because they were assessed as high risk of malnutrition. A care plan was in place based on their advice and guidance.

Weekly meetings with one visiting GP were used to good effect. For example, staff compiled a list of issues for the senior who attended this weekly meeting. This meant that non urgent changes in people's needs and new problems could be followed up at these regular consultations.

Person centred assessments and care plans were also completed. These included information that could help staff deliver person centred care, such as their favourite things, what was liked about them by other people, things they enjoyed doing and things that were important to them. The assessments were accompanied by a section entitled "My person centred care needs are:" A visiting professional told us, "For my client the quality of care is excellent. They have offered a different kind of care to other homes, have respected that she has capacity and have always sought guidance if anything has changed."

We saw care plans were reviewed each month as a matter of routine and updated as necessary. For example, some care plans had been re-written for a person who was admitted as an emergency, because the staff had learned more about the person and their needs.

Daily records were kept for each person regarding their progress and personal care. We saw the senior care staff on each floor also used daily lists of issues for the handover to each shift. These highlighted the things that were either new concerns, developments or priorities. For example, we saw on one of the lists an entry; "(name) feeling low in mood today, very tearful will need reassurance."

We saw people's individual decisions and choices were respected. For example, when a person chose not to take their medicines the staff responded appropriately. Another staff member told us, "We have a few people who prefer female carers and we can manage to do this."

The home had an activities organiser who we saw worked on different floors on different days. We saw people from all floors were invited to attend the craft activities during our visit. We talked with the activities co-ordinator, who was employed to work 30 hours per week. As well as co-ordinating she also ran many of the sessions of bingo, craft and trips out. We saw on the notice boards that a variety of activities were planned for the week and external entertainment was booked including visits from the local brownies and school children to sing carols. The home also had its own mini-bus and people confirmed they had been out in this.

We saw the 'Residents' Guide' included a reference to the provider welcoming feedback from people and a copy of the complaints procedure. The manager showed us the provider's website had enabled people and their families to pass comments on the service on-line. We saw an example of a comment passed. We saw that the service had received and appropriately responded to two complaints in the past year. For example, one person had been reimbursed for lost property and an apology letter had been sent to the family.

Good

Is the service well-led?

Our findings

In October 2014 we had been notified that the registered manager had begun a period of long term absence from the service. At the time of the inspection an experienced temporary manager was covering the service. She explained to us that the provider had asked her to mentor the deputy manager of the service, who would eventually cover the planned absence of the registered manager. We did not receive the provider information return (PIR) prior to the inspection because it arrived at CQC on the day we planned the inspection and did not reach the inspector until after the visit. However we were issued with a printed copy during our visit.

The staff we spoke with all spoke highly of the temporary manager and told us they enjoyed working at the service. Their comments included the following; "It's fantastic, the staff morale is brilliant, we get clear messages from the senior staff, they are very experienced." One staff member told us she had worked at the service for 16 years during which time there had been various managers and they had gone through some "turbulent times". She said she was very pleased to be working under the new manager who had already implemented some changes for the better. A visiting professional told us, "The manager has shown good leadership regarding my client by fighting her corner at times when other services might not have managed so well."

We saw evidence that the provider had a system for gathering the views of people who used the service and their families. Reports were produced from the results of the surveys and copies of these were openly displayed in the entrance hallway. We noted that out of 12 surveys returned the majority of the responses to the questions were positive. For example 10 responded "yes" to the questions about whether staff were competent to look after people and were polite to people and visitors. The manager showed us the process they had to follow to inform the provider of comments and complaints on-line, using an electronic web form. This included an account of the investigation and lessons learned so that the provider could monitor the progress and resolution of concerns.

We noted in our observations that senior staff demonstrated a confident and responsible approach. This supported good partnership working with local GP practices. For example, we saw that GPs carried out regular "ward rounds" with senior staff.

The PIR told us the provider had a comprehensive governance framework called Cornerstone which provides the manager with practical tools, guidance and documents designed to help deliver quality care consistently. The manager showed us aspects of this on the office computer, for example guidance concerning DoLS was included. We saw the provider held electronic records of staff training which allowed them to track staff achievements in percentages per subject and at an individual level.

The provider cultivated a caring and transparent culture. We saw their values set out in a document entitled, "The six 'C's; Care, Compassion, Competence, Communication, Courage, Commitment". This was displayed in the entrance hall and the office. The Resident's Guide and other informative leaflets about the provider and the service were also displayed, such as the results of the most recent survey of people's views. Staff told us they were clear about their roles and the manager's and provider's expectations.

Regular audits of the building and other systems were in place. For example, an infection control audit was carried out monthly. Falls were monitored and analysed. The provider issued a maintenance manual in which routine safety checks for the premises were set out in order of frequency. These measures ensured people were kept safe.

Routine accident and incident procedures were also in place and the provider had a standard processes for staff to record, report and inform them of these, so these could be monitored.

We saw care records, including the medicines administration records, were audited monthly by staff at the service and a representative of the provider visited monthly to carry out quality assurance checks. These visits led to action plans for the manager to address with given timescales. The manager showed us that she was required to provide electronic data concerning various aspects of care, including falls and other incidents. The provider took action to address any shortfalls. For example, in July 2014 they had identified that more falls happened at night. In response they had increased the number of night staff on duty.

Good

Is the service well-led?

The PIR told us the service was visited regularly by the regional quality assurance manager, service quality inspectors, finance analysts, members of the hospitality team, human resources and estates managers. The temporary manager showed us some of the reports from these visits and we saw these included action plans and target dates for improvement.

These procedures demonstrated that the provider had comprehensive systems for overseeing the performance of the service and was committed to maintaining and improving service quality.