Mariposa Care Limited

Holly Lodge Care Home

Inspection report

Maddison Street
Shildon
County Durham
DL4 1NX

Tel: 01388779265
Website: www.executivecaregroup.co.uk

Date of inspection visit:
06 November 2017

Date of publication:
11 December 2017

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 inspection took place on 6 November 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Holly Lodge Care Home 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.

Holly Lodge Care Home accommodates 40 people in one adapted building across two separate floors. The ground floor accommodation is for people with nursing or residential care needs. The first floor is a residential unit where some of the people were living with a dementia type illness. On the day of our inspection there were 39 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in September 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs.

Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Holly Lodge Care Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Holly Lodge 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 6 November 2017 and was unannounced. One adult social care inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

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 used this information to inform our inspection.

During our inspection we spoke with nine people who used the service and three visitors to the home. We also spoke with the registered manager, nurse and three care staff.

We looked at the care records of five people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

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 we spoke with told us they felt safe at Holly Lodge Care Home. People told us, "Yes I feel safe", "Yes I feel safe, because they are always there, they come as quick as they can" and "I would say so."

There were sufficient numbers of staff on duty to keep people safe. We discussed staffing levels with the registered manager. Staffing levels were calculated monthly using a dependency tool and varied depending on the needs of the people who used the service. Staff and people who used the service did not raise any concerns regarding staffing levels at the home. They told us call bells were answered promptly. Our observations confirmed call bells rang regularly but were answered in a timely manner.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

The home was clean and tidy. Communal bathrooms and toilets were well maintained and appropriate personal protective equipment (PPE) and hand washing facilities were available. The provider carried out an annual infection prevention and control audit, and a monthly infection control checklist was completed by staff to ensure people lived in a clean and safe environment.

The maintenance staff member was described as "very good" by people we spoke with. People told us he regularly carried out little jobs for them such as touching up paint work or putting up coat hooks and this was appreciated.

Accidents and incidents were appropriately recorded and audited monthly. 'Falls logs' were kept in people's care records that provided information on the incident and action taken. People had 'Post-accident/fall observation records' that were used to monitor people for 24 hours after a fall. Incidents were analysed and reflected on. Lessons learned from accidents, safeguarding incidents and complaints were fed back to staff via team meetings and individual supervisions.

The provider had a safeguarding adults policy in place and the local authority risk threshold tool was used as a guide to identify the type and seriousness of the alleged abuse. We found the registered manager understood safeguarding procedures and had followed them, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people.

A generic risk assessment was in place for the home and individual risk assessments were in place for people who used the service. These included falls, bed rails, malnutrition, choking and pressure damage. These described potential risks and the safeguards in place to reduce the risk. This meant the provider had

taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Equipment was in place to meet people's needs including hoists, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed. For example, a fire risk assessment was in place, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. An emergency contingency plan was in place and people who used the service had Personal Emergency Evacuation Plans (PEEPs). This meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation, such as a fire or flood.

We found appropriate arrangements were in place for the safe administration and storage of medicines. Medicines were stored in a locked trolley inside a locked treatment room. Temperature checks were carried out daily to ensure medicines were stored at the correct temperature

People had medication support plans in place that described people's identified needs and whether they had any allergies. Medication administration records (MAR) that we viewed were up to date and included a photograph of the person, GP contact details and details of any allergies. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A family member told us, "Yes, they always have time for him [family member]". People told us, "They [staff] are all pleasant, and do what you ask", "If the staff are not sure they get the senior in, usually they all know what they are doing" and "If I'm not well they get the GP straight away."

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

The majority of staff mandatory training was up to date and where gaps were identified, training was planned. Mandatory training is training that the provider deems necessary to support people safely. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. Staff told us they were fully supported in their role.

People's needs were assessed before they started using the service. Pre-admission assessments included details of the person's medical history and an assessment of the person's care needs, including the level of support required.

Malnutrition Universal Screening Tools (MUST) were used to identify people at risk of malnutrition. People had nutrition and hydration support plans in place. These recorded people's dietary needs and level of support required. For example, one person was identified as being at risk of poor diet and fluid intake, and also at risk of choking. The person required a pureed diet and supplements to try and maintain a healthy weight. Their support plan described how staff were to monitor and record their food and fluid intake, and weigh them weekly to monitor their weight. We saw up to date records of these. Appropriate risk assessments were in place and guidance had been sought from a speech and language therapist (SALT), which was included in the person's support plan.

People's food and drink likes and dislikes were included in their care records. We observed lunch and saw people were offered choices and attended to by smiling and pleasant staff. The majority of people ate independently with some support from staff. After the meal, people were offered support to the lounge for the 'Movie afternoon' or to their own rooms. We saw some people ate in their own rooms and were supported by staff with this. One family member told us the quality of the food was "variable", however, all the other family members and people who used the service were positive about the quality of the food served at the home.

Care records included details on people's communication needs. For example, whether they used a language other than English, visual or hearing impairments, ability to use the call bell to request assistance, and the need for visual aids or technology to support communication.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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. The registered manager maintained a DoLS matrix and records showed that DoLS had been appropriately applied for and where authorised, appropriate notifications had been submitted to CQC. Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available. This meant the provider was following the requirements of the MCA and DoLS.

Consent forms were included in people's care records for access to care records, the taking of photographs and for personal money to be held and administered by the home. Two of the five records we looked at contained completed consent records, however, the other three had not been completed. We discussed this with the registered manager who told us the care records had recently been transferred over to a new format and not everyone's records had yet been signed. They told us people's representatives would be asked to sign the forms the next time they visited the home. People we spoke with told us staff asked for consent before supporting them.

Some of the people who used the service had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service and family members had been involved in the decision making process.

People who used the service had 'Hospital passports' in place, had access to healthcare services and received ongoing healthcare support. The aim of the hospital passport is to provide hospital staff with important information about the person and their health if they are admitted to hospital. Care records contained evidence of visits to and from external specialists including GPs, social workers, occupational therapists, hospital appointments and district nurse visits.

Some of the people who used the service were living with dementia. We looked at the design of the premises for people with dementia, particularly on the first floor and found some aspects that were dementia friendly. For example, carpets were not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. Appropriate signage was in place to aid people's navigation around the home. Walls were decorated to provide people with visual stimulation. For example, photographs of famous film and music stars, and a tactile, artificial garden hedge with butterflies decorated one wall.

Good

Is the service caring?

Our findings

People told us they were supported by caring staff. They told us, "Yes the staff are caring, I've just to ask them and they see to it", "They knock on my door", "They asked if I preferred a male or female carer, I'm not bothered" and "Yes I really like it here. When I'm upset they come and talk to us." People who used the service had 'Life stories'. These had been written with the person and their family members and included information such as how the person wished to be addressed, details of their life history, preferred routines and a family tree.

People we saw were well presented and looked comfortable in the presence of staff. People told us staff were respectful. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. We saw and heard how people had a good rapport with staff. For example, a staff member was laughing and joking with two people in the foyer. The staff member said, "Are you leading her astray [name]?" A person replied, "I don't have to!"

The provider had a 'Privacy and dignity charter' that staff signed up to stating they would treat all people they met or interacted with during the course of their work with dignity and respect. We observed staff knocking on bedroom doors and asking permission before entering people's rooms.

Care records described how dignity and appearance were important to some people. For example, with regards to the clothes they liked to wear, being clean and wearing jewellery. One person's personal care support plan clearly stated they wanted female staff only to assist them with their personal care. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Care records described what people were able to do for themselves and what support they required from staff. For example, some people required full assistance from staff with their personal care, however, where people were able to support themselves this was clearly recorded. For example, "[Name] is independent with toileting but may get disorientated", "[Name] is usually quite independent with dressing and undressing but can become confused and needs guidance", "[Name] needs full assistance in all aspects of personal care" and "Carers to promote independence by encouraging [name] to do tasks that she is able to do."

People told us their independence was promoted. They told us, "I dress myself and get ready for bed myself" and "I say to them at bath time, I'll tell you if you're needed." Another person told us they liked to make their own bed in the morning. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and social occasions in people's bedrooms.

Advocacy services help people to access information and services, be involved in decisions about their lives,

explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us none of the people using the service at the time of our inspection had independent advocates, however, advocacy information was available and we saw a poster advertising a local advocacy service in the foyer.

Good

Is the service responsive?

Our findings

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. For example, people's preferences for their night time routine were recorded. These included what time people liked to go to bed and get up, whether they wanted their bedroom door closed during the night, how many pillows they preferred and whether they liked a drink before they went to bed. Care records we looked at were regularly reviewed and evaluated monthly.

'One page profiles' were completed for people that included important information on what was important to the person and how they wanted to be supported. For example, for one person it was important to give them plenty of time and encouragement.

Support plans were in place and included sleep and rest, nutrition and hydration, personal care, risk of pressure damage, mobility, mental wellbeing, communication, continence, medication and social activities. Support plans included the person's identified need in that area, the anticipated outcome, the approach required from staff and a monthly evaluation. For example, one person was identified as being at moderate risk of pressure damage due to lack of mobility. Their support plan described how they had appropriate equipment in place, two staff were to carry out frequent positional turns and to monitor skin areas. Barrier creams were to be applied to affected areas and any concerns were to be reported to the district nursing team. An appropriate risk assessment was also in place.

People had support plans in place to provide details on their end of life wishes. These provided information on the person's next of kin, whether any funeral arrangements had been made, any social or cultural traditions and whether a DNACPR was in place.

Daily records were maintained for each person who used the service in a 'Health and wellbeing' file in each person's room. Nurses and senior care staff kept a daily communication log, which was used as a handover document to pass on any important information.

We found the provider protected people from social isolation. Care records included information on each person such as what their previous occupation was, whether they had any hobbies or interests, were they a member of any clubs or organisations, and whether they had any specific beliefs or religion. This information was used to inform the person's social activities support plan.

There were various activities taking place within the home. Some people told us they did not wish to take part in all the activities so were "selective." One person told us there were "tons of things going on."

The provider had an effective complaints policy and procedure in place. Their 'Handling complaints' policy described the procedure for making a complaint and the timescales for a response to a complaint. The policy was on display on both floors of the home and an easy to read version was also available.

We viewed complaints records and saw each complaint included details of action taken and copies of responses to the complainants. For each complaint, the registered manager completed a 'Reflective practice assessment document' which recorded any areas of good practice and any areas for improvement.

People we spoke with knew how to make a complaint. Two issues that were raised during our conversations with people were discussed with the registered manager, who was aware of the issues and we found they had been appropriately dealt with.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. The registered manager showed us the refurbishments that had recently taken place in the home, including new carpets and redecoration of the communal bathrooms. An unused room was being converted into another bedroom at the time of our inspection visit.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had good links with the local community. A local community organisation helped to raise money for the home. Local school children and Scouts groups visited the home several times per year. People who used the service were taken out to the local railway museum and a local 'dementia café'.

The service had a positive culture that was person centred and inclusive. Staff we spoke with felt supported by the management team. People told us, "It [atmosphere at the home] seems quite good. They [staff] all get on together. When the entertainer came, the whole management team attended", "They can talk to you from the top down, they are forever coming round", "It's lovely. [Registered manager] often comes up, she's really nice" and "It's a nice place to live."

Staff were regularly consulted and kept up to date with information about the home and the provider. An annual staff satisfaction survey was carried out and regular staff meetings took place. Meetings were also held for night shift staff and senior staff.

We looked at what the provider did to check the quality of the service and to seek people's views about it.

The provider's regional manager conducted a monthly visit to the home and produced a report based on the visit. The visit included checks of the premises, observations and interactions with people and staff, analysis of any accidents, incidents or safeguarding incidents, complaints, checks of staff files and care records, health and safety, and business management. The provider carried out annual health and safety, and infection prevention and control audits.

The manager and senior staff carried out various monthly audits. These included care plans, health and safety, medication, dining and catering, and infection control. Any actions from these audits were recorded.

The registered manager carried out unannounced out of hours checks. These included checks of the security of the building, staffing levels, health and safety, food and fluid charts had been completed correctly, medicines had been administered on time, and call bells were answered promptly.

Newsletters were provided monthly to people who used the service and visitors. Meetings were held for people who used the service and their family members on a monthly basis. The next meeting was planned for 29 November 2017. We saw agenda items at previous meetings included home business, podiatrist, residents' smoking area, nutrition, laundry and activities.

The registered manager had an open door policy. Their office was next to the entrance to the home, where they held twice monthly surgeries so people and visitors could raise any issues.

A quality assurance survey of people who used the service was carried out in October 2017 that asked questions regarding the staff and management, premises, food and mealtimes, and your views and involvement. Surveys were also carried out of family members and visiting professionals. From these surveys, a 'You said, we did' report was collated and made available on the home's notice board. For example, with regard to food and mealtimes, more fruit had been ordered for snacks and menus had been updated so that alternative menus were more visible for people to order.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.