Prime Life Limited

Prime Life Limited - 32 South Street

Inspection report

32 South Street
Sheringham
Norfolk
NR26 8LL

Tel: 01263824040
Website: www.prime-life.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

32 South Street is a residential home that provides care, support and accommodation for up to 20 people with mental health needs. There were 17 people living in the home at the time of this inspection.

The service had a registered manager in post. 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 found that the provider was in breach of two regulations. These related to safe care and treatment and governance.

People did not live in a consistently safe environment because safety hazards were not always managed appropriately and the premises were not consistently clean and hygienic.

Identified risks to people's safety were recorded on an individual basis and there was guidance for staff to be able to know how to support people safely and effectively and minimise any risks. However, some risks were not always managed and mitigated appropriately.

There were a number of systems in place to monitor the quality of the service. Regular audits were also carried out by the manager and provider, in order to identify any areas that needed improvement. However, some of the improvements identified as required were taking a long time to complete and some audits were not effective.

People were supported by staff who were skilled and knowledgeable in their work and new members of staff completed an induction. Staff were supported well by the manager and the manager was being supported well by their direct line manager. There had been an increase in the level of support from the provider, in respect of improving and maintaining the service, although provider level decisions and subsequent improvement actions were slow.

People were helped to keep safe by staff who knew how to recognise signs of possible abuse and knew the correct procedures for reporting concerns. In addition, staff received training that was relevant for their roles and appropriate recruitment checks were carried out before staff began working in the home.

Medicines were managed and administered safely in the home and people received their medicines as prescribed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The manager and staff understood the MCA and ensured that consent to care and treatment was sought in line with legislation and

guidance.

People had enough to eat and drink and enjoyed their meals. When needed, people's intake of food and drinks was monitored and recorded. Prompt action and timely referrals were made to relevant healthcare professionals, when any needs or concerns were identified.

Staff in the home were caring and attentive. People were treated with respect and staff preserved people's dignity. Visitors were welcomed and people who lived in the home were encouraged and supported to be as independent as possible. People were also supported to follow pastimes or hobbies of their choice.

Assessments were completed prior to admission, to ensure people's needs could be met. People were involved in planning their care and received care and support that was individual to their needs.

People and their families and friends were able to voice their concerns or make a complaint if they felt they needed to. People were listened to and appropriate responses and action were taken.

The manager was well intentioned and people's needs were being met to the best of the manager and staff's ability. Communication between the manager, staff and people living in the home was frequent and effective.

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 consistently safe.

Safety hazards were not always managed appropriately and the premises were not consistently clean and hygienic.

Identified risks to people's safety were recorded on an individual basis but some risks were not always managed and mitigated appropriately.

Staff knew how to recognise signs of possible abuse and knew the correct procedures for reporting concerns.

Appropriate recruitment checks were carried out before staff began working in the home.

People were supported to safely take their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People had enough to eat and drink and made choices about their meals.

Staff were supported by way of relevant training, supervisions and appraisals to deliver care effectively.

People's consent was sought and nobody was being unlawfully deprived of their liberty.

People were supported to maintain their physical and mental wellbeing and had access to relevant healthcare services.

Is the service caring?

Good

The service was caring.

The manager and staff in the home cared about the people they supported and treated people with dignity and respect.

Visitors were welcomed and people were encouraged and supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Assessments were completed prior to admission, to ensure people's needs could be met and people were involved in planning their care.

People were able to choose what they wanted to do, how and where they wanted to spend their time.

People and their families and friends were able to voice their concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to monitor the quality of the service and regular audits were carried out to identify areas that needed improvement. However, some of the improvements identified as required were taking a long time to complete and some audits were not effective.

People's needs were being met to the best of the manager and staff's ability.

Communication between the manager, staff and people living in the home was frequent and effective.

Prime Life Limited - 32 South Street

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 was carried out by two inspectors on 18 October and was unannounced.

Before our 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. However, most of this information had been completed generically by the provider and was not specific to the service provided at 32 South Street.

Other information we looked at about the service included statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to this inspection we were informed of concerns relating to health and safety and infection control from the environmental health officer and a care home audit officer for public health. We reviewed the action the provider had taken in response to these concerns to determine how the provider ensured that people's safety was maintained in the home.

During this inspection we observed care interactions between people using the service and members of staff. We met and spoke with seven people who were living in the home. Some people were happy to speak with us, whilst others did not wish to engage in a full conversation. We also spoke with the manager and three members of care staff, including senior staff. In addition, we spoke with a member of the local authority's quality assurance team and the environmental health officer, to obtain their views on the quality of the service.

We looked in detail at the care records for four people and a selection of medical and health related records that included most of the people who currently lived in the home. We also looked at the records in respect of staff training and a selection of records that related to the management and day to day running of the service.

Requires Improvement

Is the service safe?

Our findings

People living in the home had individual risk assessments, regarding various aspects of their everyday lives. We saw these covered areas such as nutrition and hydration, smoking, personal hygiene, mobility, falls, alcohol consumption, going out in the community, specific health conditions and people's physical and mental wellbeing. Where risks to people's safety had been identified, we saw that these were recorded clearly, with guidance for staff that showed how to support people safely and effectively. Staff had easy access to these documents and we saw that they were reviewed and updated on a regular basis.

However, we observed that the guidance in place to minimise risks for people was not always being followed and some risks were not always managed and mitigated appropriately.

For example, although the house rules did not permit it, some people continued to smoke in their rooms. The minutes from a 'residents' meeting on 20 September 2016, documented that smoking in the house was now prohibited. However, we had some concerns about how safely this aspect of people's lives was being managed. For example, in three people's rooms we noted cigarette burn marks on their furniture and bedding. One person's room was very heavily nicotine stained and a number of other people's rooms smelled strongly of cigarette smoke. The manager and staff told us that they had been working with people to try and discourage this and we observed that some people had agreed to only smoke outside the premises. However, we were concerned that some people had not been supported to understand the risks of smoking in their rooms and that practical steps to reduce the risks had still not been implemented.

We observed that a number of people were using multipoint extension leads in their rooms. We saw that some people had kettles plugged into these, as well as other electrical items such as mobile telephone chargers, portable heaters and battery chargers. There was a risk that when multiple appliances were plugged in at the same time that the maximum current rating stated for the extension lead could be exceeded.

The provider told us that the extension leads that people living in the home were using had been identified as a source of ignition within the homes fire risk assessment. A fire officer from Norfolk Fire and Rescue Service also visited the home following this inspection, and did not raise concerns in respect of these or the way they were being managed. The provider also explained that all electrical circuits were protected by RCD circuit breakers which would detect an overload. In addition, portable electrical appliances and leads were tested on an annual basis. We acknowledged that these actions helped mitigate the risks of overload and fire.

However, we remained concerned that some extension leads were trailing across the floors in some people's rooms. Some were also visibly dirty and surrounded by clutter. Guidance supplied by Electrical Safety First (formerly the Electrical Safety Council) recommends having additional sockets installed if extension leads and adaptors are relied upon regularly. The extension leads we saw were in constant use. In addition, in the case of portable heaters, guidance from Electrical Safety First also states to make sure that heaters are at least a metre away from combustible materials and never to power a heater from an

extension lead. This was not the case in some of the rooms we saw. We were concerned that the risks in this regard were not being managed and reduced sufficiently. This was because people living in the home were not fully supported to understand how to use the multipoint extension leads safely.

A number of areas relating to cleanliness had been reported as requiring improvement action by a care home audit officer for public health in April 2016. We reviewed the action the provider had taken in response to these concerns and saw that a number of improvements had been made, although some areas were still 'work-in-progress'. We saw that the manager was completing regular audits on the cleanliness and hygiene in the home and the maintenance person had a schedule of works that they were in the process of completing. Although the remedial works were in progress, some of the improvements had not been completed in a timely fashion.

For example, although some sanitary ware had been replaced in the home, some remained stained and still needed replacing. One person's walking frame was also visibly unclean. In one person's room we noted significant cracks in the ceiling above the window and considerable damp patches. Three people's rooms we saw were very cluttered and unclean, with dirty linen on their beds.

At the time of this inspection, the cleaning hours were being undertaken by a designated member of staff on one to two days a week. During this inspection, the provider confirmed that external cleaning contractors were being sourced and were expected to be in place by the beginning of November 2016. This additional resource would be cleaning in the home seven days a week for two hours a day.

We acknowledged that the steps that the provider was taking to make improvements would have a positive impact on the people living in the home, as well as the environment as a whole. However, as the changes had not yet all been completed, we were unable to determine the overall impact at the time of this inspection.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in 32 South Street. One person said, "I am doing very well thank you. I go out a lot more now and I feel safe living here." A member of staff gave us examples of people who sometimes experienced anxieties regarding their safety. This member of staff explained what signs they looked out for and what action they took to reassure people and ensure their safety was maintained.

The manager demonstrated that they understood what constituted abuse and told us they followed the correct reporting procedure as and when necessary. Staff also told us that they were confident with regard to recognising signs of possible abuse and said they reported anything they were concerned about straight away. We saw that safeguarding information was available for people living in the home, visitors and staff. This information included details of who to contact in the local authority's safeguarding team. The staff training records we looked at showed that staff had received training in protecting vulnerable adults, which also helped ensure they knew how to keep people safe.

During this inspection we saw that there were enough care staff on duty to support people and safely meet their needs. The rotas we looked at also showed that staffing levels were being consistently maintained since a recent increase to the care staffing hours.

The manager explained that people's dependency was continually assessed, to ensure that staffing levels remained sufficient and appropriate. We also saw that each person's support needs had recently been

reviewed. These reviews showed how many people required more than one member of staff for support and who needed specific one-to-one support at certain times.

A discussion with the manager and the Provider Information Return confirmed that appropriate recruitment procedures were followed. This helped ensure that all new staff were safe to work with people who lived in the home. We were told that all staff were checked for suitability with the Disclosure and Barring Service (DBS) and appropriate references were obtained before they started working in the home.

Maintenance and health and safety checks were being carried out regularly by designated personnel. These checks included fire alarm tests, fire drills, safe management of water systems and Legionella. Legionella is a bacterium which can grow in water supplies and can cause people to become ill. We also noted that the service had clear evacuation plans and a business continuity plan, to ensure the service could continue to operate in the event of an emergency.

We saw that medicines were managed and administered safely in the home and people received their medicines as prescribed. We looked at the medicines storage and recording systems and saw that people's medicines were appropriately and securely stored. Some people also had lockable facilities in their rooms, for storing items such as topical creams or if they wished to self-medicate. We saw that topical medicines, such as creams and drops, showed the dates on which they had been opened. This is important, as the effectiveness of such items can deteriorate and only have a limited lifespan once opened. All the records we looked at, including the medicines administration records (MAR), were clear, up to date and completed appropriately.

Good

Is the service effective?

Our findings

People who lived in the home felt they were supported by staff who were skilled and knowledgeable in their work. One person told us, "The management and staff are excellent here at South Street."

The manager and staff we met with during this inspection had a good knowledge of each person's individual needs and people were mostly supported by staff whom they were familiar with. A member of staff told us about one person's support needs and explained, "We know if [name] isn't too good when [name] doesn't make eye contact. We increase their one-to-one time then."

The manager explained how all new members of staff completed a full induction process, which included completing essential training courses that would be relevant to their roles. Some of the training we noted that staff had undertaken included fire safety, food safety, medication, safeguarding, nutrition, mental health, behaviours that may challenge, Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (MCA DoLS). Staff and the manager told us that supervisions and appraisals also took place on a regular basis.

All the staff we spoke with said they were happy in their work and felt supported by the manager and each other. We noted that communication between the staff team was frequent and effective. For example, information was handed over appropriately at the end of each shift and daily discussions were constant, regarding aspects of people's physical and emotional wellbeing. Formal staff meetings were also held.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The manager and staff told us that they understood the MCA and ensured that consent to care and treatment was sought in line with legislation and guidance. They also demonstrated that they followed the principles of the MCA when they needed to make decisions on behalf of people lacking capacity. The manager told us that capacity assessments had been completed for a number of people who lived in the home. Some people were noted as having fluctuating capacity but nobody was currently subject to a DoLS authorisation.

During the course of this inspection we saw people having their lunch time meal. We saw that one person had soup and a sandwich, whilst another person chose just to have a sandwich. One person said they either

wanted eggs or beans for lunch and we saw a member of staff cooking eggs for them, which the person was happy with. People told us they could always have something else if they didn't like the main choice. People told us they had enough to eat and drink and said that they enjoyed their meals. One person told us that they had enjoyed their lunch and that the food was good. We also saw how people contributed ideas for the menus during house meetings and the quality assurance surveys.

We saw that the meal time was relaxed and people were not rushed with their meals. People also chose where they wanted to eat their meals. For example, two people ate in the dining room, whilst others chose to eat in the lounge. Staff demonstrated that they understood people's individual dietary requirements and there was clear information available for staff in respect of any specific needs or allergies.

We saw that staff had completed a screening tool for each person (MUST), to identify anyone who may be at risk of malnutrition. Staff and the manager explained that when these risks were identified, people's intake of food and drink was monitored and recorded. This would enable appropriate action to be taken promptly, to help ensure people stayed healthy and well.

In respect of people's general physical and mental health and wellbeing, we saw that people had regular access to relevant healthcare professionals when this was needed. For example, one person had their eyes examined regularly, because of their diabetes. Another person had received input from the speech and language team, due to some difficulties with swallowing. We also saw that other people had regular contact with their GPs and mental health specialists. The manager and staff told us that they regularly sought and followed guidance from external healthcare professionals. This helped ensure people were supported and cared for effectively.

Good

Is the service caring?

Our findings

People told us that the staff in the service were caring. One person said, "I love it here, I absolutely love it!" This person went on to tell us how lovely the staff were and how they were all very kind and caring.

Nine people who lived in the home had completed the 2016 Quality Assurance survey. We saw from the results that all nine people had responded positively to the questions about staff being caring and respectful. All nine people had also given positive responses when asked whether the care and support was provided in a dignified manner. One person had commented, "I am very happy with all the help I get here and I find the staff cooperative."

We saw that people were treated with respect and that staff preserved people's dignity. For example, bedroom doors were knocked upon before staff entered. People were also discreetly prompted or assisted, when they required any support with their personal care needs.

All the staff on duty during our inspection had a good knowledge and understanding of each person. Discussions with the manager and staff, plus our observations of staff interactions, confirmed this. We saw that staff interacted well with people in a warm and friendly manner and observed mutual joviality and light hearted conversations during our inspection. People were comfortable in the presence of the staff who were supporting them. We also saw that staff gave their full attention when people spoke to them and noted that people were listened to properly.

People who lived in the home had been involved in planning their care, as much as they wanted to. This was evident from the information we looked at in people's care records, observations and discussions with people who used the service. The care records we looked at also reflected people's personal histories, wants, needs and preferences.

People were encouraged and supported to be as independent as possible. A member of staff explained how they encouraged people to maintain their independence by encouraging people to make drinks for themselves and choose how and where they wished to spend their time.

Visitors were welcome without restrictions and, where possible, people had regular contact with family members or friends. If people did not have any family, we noted that they were supported to access an independent advocate if they wished. A member of staff told us how one person had regular contact with a close family member. The staff explained that this family member sometimes got upset and worried for their relative's safety and wellbeing. The staff said that they always took the time to reassure the family member and had built up trust with them. This had a positive impact on the person living in the home as well as their family member.

Good

Is the service responsive?

Our findings

We saw that people had been involved in planning their care and received care and support that was individual to their needs. We heard staff engaging naturally in conversations with people, as well as checking whether people were okay. We saw that when anybody requested support or assistance, staff were quick to respond. For example, we noted that one person required some assistance with their personal care after lunch and we saw that staff supported them straight away.

A discussion with the manager and information in people's care records showed that each person completed an assessment, prior to their admission to the home, to help ensure their needs could be met. We saw that these pre-admission assessments were used to form the basis of people's care plans and risk assessments. People's care records and risk assessments we saw had been reviewed and updated, where needed, on a regular basis.

The contents of people's care plans were personalised and gave a full description of need, relevant for each person. The care records included information that was totally specific to each individual. For example, we saw that one person was diabetic but that this was diet controlled and the person understood how to manage this well by balancing their meals. We also noted that this person chose when they got up in the morning and when they went to bed at night. It was recorded that this person liked to go into town on their own and sometimes met up with friends from the local church. We observed this to be the case during our inspection.

We saw that people living in the home made decisions for themselves in respect of what they wanted to do and how or where they wished to spend their time. During this inspection we saw that some people chose to spend time in their rooms, whilst others sat in various communal areas, such as the kitchenette or the lounge. Some people also chose to access the local community.

A member of staff told us how one person liked to be helpful in the home and often helped staff to do the dusting. The staff member also told us how this person attended a support group in the community several times a week, where they enjoyed trips out, gardening and other activities. The staff member told us how one day the person had decided not to go to their group but then changed their mind, so staff arranged for a taxi to take the person at a later time. This example helped demonstrate how the service was responsive to people's individual needs.

People told us that they could make a complaint if they needed to and could raise any concerns, at any time, with the manager or staff. People also said they felt appropriate action would be taken to 'put things right'.

Requires Improvement

Is the service well-led?

Our findings

The provider's nominated individual visited the service on 5 October 2016 to provide oversight for the home. A further visit was scheduled for 19 October 2016. The visit report showed that the nominated individual had reviewed the progress of the required improvement works. As a result of this visit, we saw that the nominated individual had authorised additional refurbishment work to be carried out.

Although we saw 'work in progress' for a number of required improvements that had been identified, some actions were not completed in a timely fashion. For example, one person had experienced a water leak through their bedroom ceiling. Although we saw that the leak had been repaired and the ceiling had been 'patched' the full repairs and decoration would not be completed until it fitted in with other scheduled works in the home. We were told that these works had begun to be carried out with effect from 10 October 2016 and were expected to take four to six weeks to complete. However, as all the work had not yet been completed, we were unable to determine the overall impact at the time of this inspection.

There were a number of systems in place in order to ensure the quality of the service provided was regularly monitored. For example, we saw records of a weekly action plan that the manager completed. This showed aspects of work that had been completed such as interviews for new staff, arranging funding reviews for people who lived in the home and completing inductions with new care staff.

The manager also completed a regular 'work session record' with their line manager. This was an audit tool that enabled checks on the progress of various required works, as well as confirming when work had been completed. We saw from the work session record dated 14 October 2016 that some areas still required action, which had been ongoing since May 2016. For example, some elements of the infection control action plan still needed to be completed.

Care plans and people's individual assessments in respect of risk, were audited, reviewed and updated regularly. The manager and designated staff also carried out regular audits covering areas such as health and safety, medicines, falls, accidents and incidents. However, these were not always effective. For example, we were concerned that the health and safety audits had not identified that the risks in respect of the extension leads were not being sufficiently managed or reduced.

We concluded that although audits of the home identified any negative trends, the risks were not always being mitigated in a timely way. For example, a fire officer from Norfolk Fire and Rescue Service completed a follow up visit at 32 South Street on 27 October 2016. This person confirmed that the outstanding fire safety works had been completed and that no further intervention by the fire department was currently planned. However, the fire officer also stated that there did appear to be undue delay between defects being identified and works being carried out.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the manager and staff managed 32 South Street well on a day to day basis and that things were much improved since the additional care staffing hours had been implemented. One member of staff told us, "It's a good team here and [Manager] is very supportive." This person also said, "Our care of the residents is our strong point. People's care and one-to-one time comes before cleaning." They added that more staff and more time would be good and that the new contract cleaning hours would make a big difference.

There was a registered manager in post, who understood their responsibilities and reported notifiable incidents to CQC as required. The manager was responsible for both 32 South Street and another nearby service, also owned by the provider. Although divided between the two locations, we saw that the manager had an open door policy and was clearly visible within the home.

We noted that people living in the home had opportunities to provide feedback regarding the quality of the service provided, by way of daily discussions, quality assurance surveys and 'residents' meetings. The manager told us that, where possible, suggestions for improvements were listened to and action taken, with the involvement and inclusion of the relevant people. Nine people who lived in the home had completed the 2016 Quality Assurance survey. We saw from the results that all nine people had responded positively when asked if they were able to talk with the manager or senior team when needed.

Communication between the manager and the staff team was noted to be frequent and effective, with daily discussions and formal staff meetings. The staff meetings covered aspects such as training, housekeeping and other service specific topics. On changing shifts, staff handed over information to each other and discussed the health and wellbeing of people living in the home. Any concerns, issues or requirements were highlighted at this point, to ensure people had continuity of care. We also noted that the staff team as a whole regularly took note of people's comments, thoughts and feelings to help try and ensure they could have a good quality of life.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with untimely and inadequate action to reduce identified risks. Regulation 12 (1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not sufficiently protected because the provider did not take timely action to mitigate identified risks. Regulation 17(1)(2)(a)(b)