Prime Life Limited

Holmes House Care Home

Inspection report

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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

We inspected the service unannounced on 9 September 2015 and returned announced the next day.

Holmes House provides accommodation and personal care for up to 78 older people. At the time of inspection there were 62 people living in the home. The home is made up of two units, Holmes House and a newer purpose built facility, Holmes Court.

The service has a registered manager. 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.

People using the service told us they felt safe. Staff knew how to recognise signs of abuse and knew how to report concerns about people's safety. The provider had procedures to investigate and learn from incidents and accidents.

The service worked closely with the local authority to reduce the risk of people experiencing injuries as a result

Summary of findings

of falls. Risks associated with people's care and support were assessed and actions taken to minimise the likelihood of those risks occurring. People received their medicines at the right times apart from when that had not been possible. The service had discussed those instances with the prescribing doctor.

The provider had robust recruitment procedures that ensured as far as possible that only people suited to work at the service were employed. Enough staff were deployed to meet the needs of people using the service.

Staff received support through training and supervision to be able to meet people's needs. Special training was arranged to teach staff how to support people who at times demonstrated behaviour that challenged others. Staff had opportunities to attend specialist dementia awareness training. Staff were aware of the relevance and requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People using the service were supported to have their nutritional and health needs met. Staff made appropriate referrals to health service specialist and people were supported to access health services when they needed them.

Staff were caring and showed compassion when they supported people. Staff understood people's needs and involved people in decisions about their care. Staff respected people's privacy and dignity.

People received care and support that was centred on their individual needs. People's care plans were regularly reviewed. Information about people's interests and hobbies was used to develop a range of meaningful activities. People using the service and their relatives knew how to raise concerns and were confident they would be listened to.

People using the service, their relatives and staff were involved in developing the service. Their views and suggestions were acted upon. Some staff felt the reasons their ideas and suggestions were not acted on were not always explained. However, staff felt well supported by the management team and felt that the home was improving and that staff morale was good.

The provider had robust procedures for monitoring and assessing the quality of service. They were committed to continuous improvement.

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.

People told us they felt safe. They mostly received their medicines on time and there were enough staff to meet their needs.

Staff knew how to identify and report signs of abuse.

Good

Is the service effective?
The service was effective.

People felt staff were suitably skilled and knowledgeable about their needs.

Staff felt their training helped them to be able to meet the needs of people they supported.

People's nutritional and health needs were provided for.

Good

Is the service caring?
The service was caring.

People felt staff were kind and compassionate.

Staff were attentive to people's needs.

People were involved in decisions about their care.

Good

Is the service responsive?
The service was responsive

Delivery of care was focused on people's individual needs.

People were supported to follow their hobbies, interest and things that were important to them.

People knew how to raise concerns and were confident they would be listened to.

Good

Is the service well-led?
The service was well led.

People using the service and staff were involved in developing the service.

People using the service, relatives and staff felt they could approach the registered manager with any concerns.

There were effective arrangements for monitoring the service.

Good

Holmes House 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 We inspected the service earlier than planned because of a high number of notifications we received from the provider concerning serious injuries to people using the service.

This inspection took place on 10 September 2015 and was unannounced. We returned announced the next day.

The inspection team consisted of two inspectors, a specialist nurse adviser and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for elderly people.

Before the inspection we reviewed the information we had received about the service since our last inspection in November 2014. This included notifications we received from the provider about incidents where people using the service had experienced injuries or alleged abuse.

We spoke with eight people who used the service and relatives of six people using the service. We used the Short Observational Framework for Inspection (SOFI) to observe 10 people who used the service. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider's regional director who was at the service at the time of our visit. We also spoke with the registered manager, deputy manager and seven care workers. We looked at 14 people's care records. We looked at a recruitment file, staff rotas and at the provider's quality assurance records.

We spoke with three officers from the local authority who visited the service on 9 September 2015 in connection with a project concerning supporting people who were at risk of falls or who had experienced falls at the service.

Good

Is the service safe?

Our findings

People told us they felt safe. A person said, "I feel safe. I'm quite happy here." Others told us they felt safe because the staff were caring. A relative told us, "I'm confident [person using the service] is safe." Other relatives told us about actions the service took to make people feel safer after they had experienced falls. One told us, "[Person using service] has fallen out of bed and ended up in hospital, this knocked her confidence. There is now a crash mat in place."

Several people using the service had experienced falls some of which resulted in serious injuries. In the first six months of 2015 there had been more falls at the service than in the whole of 2014. The provider cooperated with a local authority run project to reduce the risk of people having falls. Actions taken included people having eye tests to see if their vision was a contributing factor to them falling, people were supplied with walking aids and encouraged to wear anti-slip footwear. Lighting had been improved in areas of the home. Staff took more attention to detail such as which side of the bed people got out of and layout of furniture in their rooms and layout of communal areas. As a result of those actions the number of falls had reduced and people were better protected from the risk of falls.

Staff we spoke with knew how to recognise and report signs of abuse. They told us they observed whether people's mood, behaviour, eating and sleeping patterns changed as a sign of possible abuse. Staff also made discrete observations of people to check whether they were safe, for example whether they showed signs of anxiety or needed prompt support. Staff were confident that any concerns they raised would be taken seriously by the registered manager. The provider had policies and procedures covering safeguarding. Staff were aware of those. We saw that the provider promoted safety and welfare of people through posters and staff communications. Information about a `whistle blowing' contact number was prominently displayed where visitors could see it. Staff knew they could raise any safeguarding concerns directly with the local authority safeguarding team or the Care Quality Commission. A care worker told us, "If I if felt concerned regarding the safety of a resident I would report to senior staff, area managers and eventually whistle blow if I was not happy with steps taken."

Visitors we spoke with told us they knew how they could raise any concerns they had about their relative's safety. One told us, "I've never seen any sign of unexplained injury. If I did, I'd talk with the manager."

We saw staff supporting people with their mobility. Staff used safe techniques to support people to get in and out of chairs and to walk safely. Staff were trained by local authority specialists about how to support people who were assessed as being at risk of falls. When hoists were used to lift people, this was done safely. We saw from training records that staff were trained to use the equipment safely. Equipment such as hoists and stand aids were serviced in accordance with manufacturer's instructions.

People's care plans included assessments of risks associated with their personal care routines and other risks such as risk of falls. The risk assessments contained information for care workers about how to support people safely to minimise the risk of harm. Risk assessments were reviewed monthly or more often if a person's circumstances changed. We saw, for example, that risk assessments of people with pressure ulcers were regularly reviewed. The care and support they received took account of the risk assessments and their conditions improved.

The provider had procedures for reporting and investigation of accidents and incidents. Staff we spoke with were familiar with those procedures. Accident and incident reports were investigated by the registered manager or deputy manager. We saw evidence that investigations established why incidents or accidents had occurred and that actions were taken to reduce the risk of similar events occurring again. This was especially evident in relation to people experiencing falls.

The registered manager was responsible for deciding how many staff should be on duty in line with the provider's procedures. These took into account the assessed and changing needs of people using the service. People using the service told us they felt enough staff were on duty. One person told us, "When I want anything doing there are always staff to do it for me." Other people told us that staff were often busy but that they had not had to wait long if they requested anything of staff. A visiting relative told us, "There seem to be enough staff about at times, but there is lack of supervision of residents in the lounge. We sit for long periods of time with our mother and no staff are about." We took that person's comment into account when

Good

Is the service safe?

we made observations about the deployment of staff. We found that staff made discrete observations of people in the lounge from outside the lounge. Another relative told us, "If [person using the service] requires assistance staff come straight away." Peoples feedback to us and our own observations showed that enough staff were deployed.

Staff rotas and training records we looked at showed that sufficient numbers of suitably skilled and experienced staff were deployed.

People we spoke with told us they were given their medicines when they needed them. A relative of a person using the service told us, "I've seen staff prompt [person using the service] to take their medications". However, when we looked at two other people's medicines records we found that one had not been given some of their medicines on 7 and 8 September 2015 and the other person had not been given a medication on 8 September 2015. When we looked into this we found there were explanations why the medicines were not given, but these had not been recorded. The registered manager told us they would remind staff that they must record why a person had not taken their medicines.

A relative of a person using the service told us, "At one time a staff member was giving my relative medicine which clearly said should be given after meals, but it was offered before meals. I had to challenge this."

The provider had a medicines management policy which clearly set out requirements for safe storage, administration, recording and disposal of unused medicines. The policy was followed most of the time, but we identified a medicine that should have been disposed in June 2015 was still in stock. This was acted upon after we brought it to the registered manager's attention. When we observed a medicines administration round, this was carried out safely and in line with the provider's procedures.

Good

Is the service effective?

Our findings

When we asked people using the service about staff that supported them they spoke in complementary terms about them. A person using the service told us, "I have found staff good and helpful". Another person said, "I like the staff." A relative of another person told us, "The staff are good. I'm confident [person using the service] is well looked after."

Staff told us they felt they had sufficient induction training. This included shadowing experienced staff. This is learning on the job training which involves working with more experienced member of staff for a period after commencing the role. All care staff we spoke to told us that they have good training support. Staff told us about training they had and this included moving and handling, first aid and safeguarding which are all important to enable carers support the people using the service. Staff we spoke with told us that they have not had any training how to support people when they displayed behaviour that challenged. We saw an instance where a care worker would have benefited from that training. They were seated close to a person who repeatedly said "Please take me home in a minute." The care worker responded each time by saying, "I will in a minute" which was not an appropriate response. We discussed this with the registered manager who told us that training about how to support people at times they displayed behaviour that challenged had been scheduled to take place shortly after our inspection. We knew the provider had arranged similar training at another location that had proved to be effective. Although not all staff had that training, we saw feedback from a relative that complimented staff on how they supported people who at times presented behaviour that challenged others.

Several people using the service lived with dementia. The provider had produced an information leaflet about dementia for relatives. The provider had also arranged for a specialist charity to deliver a specialist dementia training course for staff. The provider had organised for the registered manager at Holmes House and registered managers at other locations to attend a theatre production about living with dementia. Learning from those initiatives was cascaded to staff at staff meetings. A care worker told us, "I've had the dementia training. I learn something new every day." The registered manager had begun work on creating a `dementia friendly' lounge to replace an existing but smaller room where people with dementia could spend time.

The provider had procedures to support people through supervision and training. Supervisions are meetings between staff and their manager where they can discuss the staff member's role, performance, support needs and any concerns. They are intended to provide one to one support to the staff member. Staff also had short focused meetings and short training sessions of single specific topics. Senior carers told us they had supervision meetings every 3-6 months. We saw a schedule of planned supervision meetings for all staff that were to take place over the forthcoming months.

Staff we spoke with showed they had awareness of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS are law which protects people who lack mental capacity to make decisions about their care and support. DoLS are safeguards under which providers of care must not inappropriately restrict people's liberty, for example by use of inappropriate restraint. In the case of people who live in care and nursing homes, DoLS authorisations are made by the local authority. Several people using the service were under a DoLS authorisation. Staff we spoke with knew who they were and understood about the support those people required. We saw from training records that staff had training about MCA and DoLS. A care worker we spoke with told us, "The training which I have been on has been relevant to the work I do. It included DoLs and MCA."

We saw that when staff provided care and support they first asked a person if they wanted that support, for example when staff offered people their medicines during a medications round.

Staff we spoke to were able to give us detailed information about the people that they supported. The information they gave corresponded with the information in people's care plans. Staff knowledge of people's needs, history and preferences meant they understood the people's needs.

People told us they enjoyed their meals. A person told us what they'd had for lunch and added, "It was alright. I had a choice of what to have." Another person said, "I liked my lunch. There was lots of choice, there always is." A relative told us, "The food is quite good, always nicely presented

Good

Is the service effective?

and the residents get to choose". We saw staff offering people choices of meals either verbally or by showing pictures of meals or plated meals they could choose from. People chose where they wanted to sit to have their meals. When we observed a meal time people appeared to enjoy their meals. People who required support with their meal were supported. They were able to eat their meals at a pace that suited them because staff did not rush them. Staff sat with people they supported and engaged with them.

People's care plans included information about people's dietary and nutritional needs. Information about any special dietary needs, for example for people who were diabetic, people who required food supplements, soft food or food cut into small pieces was known to staff. That information was also known to the cook and kitchen staff. This ensured that people were given the right food. A person using the service told us, "I have no reason to complain about the food". They explained they had gained weight since coming to the service, which was something they wanted to do.

People's nutritional needs were monitored daily by care staff. Staff kept records or what food and drink people were offered and how much they ate and drank on food and fluid charts. We looked at ten fluid charts and found that six included errors that were made when staff added up how many centilitres of fluids people had drank. These errors were corrected immediately after we brought them to the attention of a senior care worker. We discussed the design of the fluid chart with the registered manager who made changes to the chart to make it easier to complete and use as a monitoring tool.

People's care plans included information about people's health needs. Staff told us they looked at people's care plans to maintain their knowledge of people's needs. They were kept up to date about people's needs through `handover' meetings which occurred when they arrived at work for the beginning of their shift. A care worker told us, "The handovers are useful and informative." However, a relative told us that had not always acted on advice from a district nurse. They told us, "It was instructed by the district nurse to put mum back to bed for bed rest after lunch as she had a fall recently but this was not actioned. Many times I would come and visit and mum was still in a chair after lunch. I was told [by staff] that they had not been told at handover."

Staff were attentive to people's health needs. A care worker told us, "If I noticed that a resident was losing weight rapidly, I would contact the GP and dietician. Another care worker described how they would recognise the symptoms of low blood sugar levels in a person with diabetes and how they would respond. What they told us reflected good and safe practice. We saw from records we looked at that the service made referrals to dietary and nutritional specialists when it was appropriate to do so, for example when people had experienced unplanned weight loss. Referrals were made to other specialists, for example occupational therapists and district nurses. People were also supported to attend appointments at dentists, opticians and medical centres.

Good

Is the service caring?

Our findings

People told us staff were kind. A person told us, "I like the staff, I'm quite happy here." A relative of another person told us, "The staff are very helpful" and another relative said, "The staff are very caring."

Staff supported people in ways that showed people using the service mattered to them. Staff used people's preferred names when they spoke with them. A care worker spoke about how they tried to make people feel they mattered, they told us, "We can't expect to see people sitting watching TV all day, so we now talk more with people. It's what they need in their lives." We saw staff engage in conversation with people about things that were of interest to them. Staff were aware of people's life histories and interests and we heard staff talking to people about those things.

Staff showed a caring attitude. We heard staff ask people if they were comfortable and they helped them adjust their posture to be more comfortable.

The service had arrangements that sought to ensure people's washed clothes were returned to their rooms, but these had not always worked. A visitor told us that on occasions they had found that their relative was dressed in other people's clothes. This was a matter of detail that could be important to people.

People who were able to be were involved in decisions about their care. This was through a mix of informal and formal methods. People told us that they discussed aspects of their care and support with staff and that staff listened to them and acted on what they said. This was evident at the level of routines that people enjoyed. A person described that they and staff agreed that "[they] were free to come and go as they pleased and go outside for a cigarette when I like". At a more formal level people's care plans were regularly reviewed with the involvement of people using the service.

A relative told us they felt involved in decisions about their parent's care and support. They said, "The staff are very good at keeping me informed." Another relative told us, "Staff involve me. They always give me an update. I feel close to the staff." A third relative we spoke with expressed how grateful they were to be involved. They told us, "I was involved in mum's end of life plan."

People using the service and relatives were informed about what the service could do for them through an information pack. The provider also communicated information through newsletters that were on display very close to where visitors had to sign a visitor's book. Information about independent advocacy was included in an information leaflet.

Staff respected people's privacy. People were able to spend time in different areas of the home, including in a `quiet room'. The layout of the communal lounge had been changed to afford people more privacy and to enable them to sit amongst people they wanted to sit with as opposed to sitting in a large open area. We saw people spending time in the quiet room. Staff respected people's privacy when they provided personal care. Door signs were used to indicate that personal care was being provided and that people should not enter the room.

The provider promoted `dignity in care' at the location. Two people using the service were appointed as `dementia friends' after the provider had participated in an initiative run by the Alzheimer's Society. This increased those people's awareness of dementia and their understanding of people living at the home with dementia. Staff received training about what dignity in care meant in practice. Training was reinforced at staff meetings, staff newsletters and bulletins and posters. The service had staff who were trained to be `dignity champions'. Their role was to support and encourage staff to practice dignity at all times. For example, to remind staff to address people by their preferred name instead of by terms such as `darling' or `love' unless it was known that people using the service did not object to that.

People's relatives were able to visit them without undue restriction. During our inspection relatives visited throughout the day including in the evenings. Entries in the visitor's book showed this was always the case. People using the service could feel confident they could receive visits when they wanted from people that mattered to them.

Good

Is the service responsive?

Our findings

We saw from people's care plans that they were involved in the assessment of their needs and planning of care. They felt that their needs were met. A person using the service told us, "The staff are alright. If I want anything they do it for me." Another person told us, "I don't need much, but what I need is there." A relative told us, "I've been involved and asked for my views."

People using the service and relatives were invited to `residents meetings' where they contributed to discussions about aspects of the service. People and relatives made suggestions about food menus, activities and facilities which the provider had acted upon. An example was that staff had noticed how much people enjoyed a visit from a group of people who brought a variety of animals with them for people to learn about. After that the service arranged for budgerigars and hens to be `pets' at the home. People were involved in naming the pets which was something they told us they enjoyed doing.

People's care plans contained information about what was important to them and how they wanted to be cared for and supported. Staff we spoke with were familiar with people's needs because they referred to people's care plans. They knew about people's interests. An example was when a person mentioned something about their interest in the second world war, a care worker told them about a television programme about the war and switched the channel on the television so the person could watch the programme.

People with faith needs were supported to practice their faith because the registered manager arranged for representatives of local places of worship to visit the home.

People were supported to follow their hobbies and interests. People who liked to knit were provided with what they needed to follow that interest. When a care worker discovered that a person liked drawing and writing they put into practice training they had recently attended to support that person with their hobby. An external training evaluator was so impressed by the care worker's efforts that they supplied colouring pens, writing pens and adult colouring books. We saw evidence of those things being enjoyed by people using the service. Some people enjoyed watching particular programmes on television and staff reminded people when the programmes were on so they could watch them in their rooms or in the communal lounge.

The service did not have a full- time activities coordinator but a care worker had taken a lead on arranging and providing activities. They told us they had been supported in that role to develop and introduce activities that people liked. On both days of our inspection we saw people taking part in sing-a-longs which they clearly enjoyed. Relatives and staff we spoke with told us that more activities were taking place than before. A care worker told us, "A lot has changed here. There is more interaction with people now." A redesign of the communal lounge supported people to interact with other people. Seating was now arranged in clusters and we saw people engaging in conversation with others.

We saw photographic evidence of social and other activities that had taken place since our last inspection. These included concerts by visiting singers and entertainers, cooking classes, sessions with animals, gardening and trips to places that were of interest to people using the service.

The service was awarded a certificate of achievement by a national accredited body for the activities that were provided for people using the service.

Staff supported people to avoid feeling lonely or socially isolated. A relative of a person using the service told us, "[Person using the service] was not able to come downstairs before, but we had a chair made especially for her. Now she is downstairs with the rest of the residents instead of being in the room on her own." The service provided a computer with a social media facility for people to use stay in contact with family and friends.

People's care plans were regularly reviewed, usually by the registered manager, the deputy or senior care workers. We saw from care plans we looked at that modifications were made to reflect people's changing needs. For example, staff identified that two people's sleeping patterns had changed. That change meant those people were asleep at times they were to be given prescribed medicines. In response, the registered manager contacted the prescribing GP to ask if medicines could be given earlier when the people were still awake.

Good

Is the service responsive?

People we spoke with told us they felt well cared for. People's care plans were focused on people's individual care needs. We saw care plans that included information for care staff about how to support people with specific needs, for example support personal hygiene, eating and drinking and pressure care.

Plans included clear guidance for care staff about how to support people with pressure ulcers, diabetes and other conditions. Plans and care records showed that people's wellbeing improved because of the care they received. A relative of one of those people told us, "There are definite signs of stability and there has been no regression. The staff have been very responsive and very helpful."

The provider had arrangements for seeking the views of people using the service and their relatives. These included a comments book, residents meetings and an annual survey. People's views and suggestions were acted upon, for example in relation to activities.

The provider had procedures for investigating concerns about the quality of care. Internal investigations sought to establish why incidents of concern occurred. The registered manager cooperated with the local authority when they carried out safeguarding investigations. We saw evidence of learning from those investigations. For example, actions were taken to reduce the risk of falls and injuries from falls. The provider was committed to using people's feedback to drive improvement at the service.

Good

Is the service well-led?

Our findings

People told us they felt listened to. A person told us that they and other people using the service enjoyed playing pool and snooker. They mentioned that at a resident's meeting and the registered manager ordered a pool table which arrived on the day of our inspection. We saw two people using the service assemble the table. People were involved in developing the service in the sense that their ideas and suggestions were acted upon. Usually this was in connection with activities at the service.

Staff had opportunities to be involved in developing the service through staff meetings and supervision meetings. A care worker told us about how they had been supported to develop a wider range of activities for people using the service. Another said, "After meetings sometimes we wait months before issues are acted upon from supervision or staff meetings". Another care worker had a slightly different view. They told us, "We are able to make suggestions, but it's not always explained why suggestions are not taken on board." However, staff were generally positive about the service.

The registered manager established links with the local community. As a result, students from a local college visited the home to provide companionship and conversation to people using the service. The registered manager worked with an external organisation on a project to involve people from the local area in events and activities at the service. The manager from the external organisation told us, "It was lovely how we worked together." They explained that people from the local community and people using the service had established good relationships during the period of the project.

Staff we spoke with told us they were confident about raising concerns about the service by talking with the registered manager or using the provider's whistle blowing procedures. The registered manager and senior care workers supported staff to practice dignity and compassion when they supported people. They did this through providing mentoring, arranging training and discussion at staff meetings.

People and relatives we spoke with knew who the registered manager was. They knew who the senior care workers were. They told us they were confident about approaching any of those people if they had concerns.

The registered manager understood their responsibilities. They were supported by a regional director who visited the service regularly. They in turn were supported by the provider's `operational board' which consisted of the provider's most senior people. The provider had a library of policies and procedures that the registered manager was guided by. People using the service could be confident that the registered manager reported everything they should to the Care Quality Commission so that we had an overview of the service.

The registered manager, deputy manager, senior care workers and care workers all had a shared understanding of the challenges facing the service. The management team and staff worked together to improve the service in response to local authority inspection visits and CQC inspections.

The provider had procedures for monitoring and assessing the service that operated at two levels. The registered manager carried out checks and audits in line with the provider's quality assurance procedures. These included reviews of people's care plans and care records to check that they were receiving safe and effective care. Other audits, for example audits of medications management, were carried out to monitor compliance with the provider's policies and procedures and operational aims, objectives and targets.

Since our last inspection the provider had introduced a `Quality Matters Toolkit' for registered managers. The purpose of the toolkit was to support registered managers to provide leadership that ensured people using the service received quality care from a motivated workforce. Comments from staff we spoke with included, "It's a much happier place" and "Morale is better, team work is better. We all give our best."