Prime Life Limited

Fir Close

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

Summary of findings

Overall summary

The inspection took place on 5 April and was unannounced.

Fir Close is registered to provide accommodation for personal care for up to 34 older people or people living with dementia. There were 32 people living at the service on the day of our inspection. The service was accommodated in two buildings: Field View and River View.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment.

People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. The registered manager ensured that there were sufficient numbers of staff to support people safely. People were given their medicine safely.
People were cared for by staff that had knowledge and skills to perform their roles and responsibilities and meet the unique needs of the people in their care. Staff received feedback on their performance through supervision and appraisal

People had their healthcare needs identified and were enabled to access healthcare professionals such as their GP, district nurse and community mental health team.
People where able were supported to make decisions about their care and treatment and staff supported people to maintain their independence. People were treated with dignity and respect by kind, caring and compassionate staff.

People were treated as individuals and received care that was person centred. People were involved in planning the menus and staff supported them to have a nutritious, varied and balanced diet.

The registered provider had robust systems in place to monitor the quality of the service, including regular audits and feedback from people, their relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff on duty to meet people's needs.

Staff followed correct procedures when administering medicine.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff who had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

People had their healthcare needs met by appropriate healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care was regularly assessed, planned and reviewed to

meet their individual care needs.

People were supported to maintain their hobbies and interests, but there were limited organised activities.

Is the service well-led?

Good

The service was well-led.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

There was an open and positive culture which focussed on people and staff.

People who lived in the service and their relatives found the registered manager approachable.

Fir Close

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.'

The inspection took place on 5 April 2016 and was unannounced. The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the senior carer in charge of the service, three members of care staff, the cook, the housekeepers, and 12 people who lived at the service, a visiting health professional, three visiting relatives and two regional directors. We also observed staff interacting with people in communal areas, providing care and support. In addition we spoke with one visiting health professional.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for 10 people and medicine administration records for seven people.

Good

Is the service safe?

Our findings

People who lived in the service told us that they felt safe living there. One person told us, "I feel safe here, I used to fall at home but I've not fallen once here!" Another person said, "I feel safe because the people here are the same age as me. They always check me at night to make sure I'm okay. They look after me very well." One person's relative spoke of the benefits of their loved one living in the service and said, "I think it's a very safe environment. It means she's not wandering around or leaving the electric on. It gives me real peace of mind to know she's being looked after."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe, knew how to recognise signs of abuse and action to take. One member of care staff said, "We need to look after their needs and wellbeing. Abuse is not nice and there are different types. I would go straight to the manager and if needed to take further action. I would go to CQC and safeguarding. We have the phone numbers."

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There were systems in place to support staff when the registered manager was not on duty. Staff had access to major incident procedures that included plans to be actioned in an emergency situation such as a fire or electrical failure. In event of people being evacuated from the service, contingency plans were in place to accommodate people in others services run by the provider. In addition, staff had access to on-call senior staff out of hours for support and guidance.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such the use of bed rails, safe moving and handling techniques and falls. Care plans were in place to enable staff to reduce the risk and maintain a person's safety.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post.

We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly. People who lived in the service and their relatives told us that there were enough staff to look after their care needs. One person said, "I just have to buzz and staff come running." Another person said, "We don't usually have to wait for the bell, but they do seem run off their feet a lot of the time."

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. People told us that they always received their medicine on time and care staff always asked them if they needed any medicine for pain. We observed lunchtime medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. The senior member of care staff wore a red tabard to alert other staff not to interrupt their medicine round, to reduce the risk of medicine errors.

We looked at medicine administration records (MAR) for seven people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. We saw that people who were on a short term placement had advice sheets on how to take their medicine safely in preparation for their safe return home. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person declined as required pain relief. We saw where a person had their medicine prescribed to be administered covertly that there was signed authorisation by the person's psychiatrist and the pharmacist had been involved to dispense their medicine in liquid format. Covert is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.

We looked at the clinical rooms in both Field View and River View and found that medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. A senior member of care staff told us that all medicines incidents were reported through a formal route and the registered manager investigated them.

Good

Is the service effective?

Our findings

People who lived at the service told us that staff had the knowledge and skills to carry out their roles and responsibilities. One person said, "They're very good, they know what they're doing, they are always giving good advice." Another person told us, "They seem very capable to me."

Staff were provided with a range of training and professional development opportunities. For example, staff attended mandatory training such as health and safety and infection control. Staff also received training specific to individual needs, such as safeguarding training for all staff and an in-depth six month college course on dementia for care staff. In addition, staff were supported to work towards a nationally recognised qualification in health and social care. We saw that staff training needs had been identified for 2016 and training sessions had been arranged. Staff told us that the provision of training was very good. One senior staff member spoke about their development opportunities and said, "The manager is very supportive and got me all the training I need. I am very excited about it." Another staff member explained the benefits of training and said, "I have learnt a lot since I came here. I now know about the dementia side of things, I didn't know about the different types before. I have more of an understanding why they do the things they do. Some may think they are naughty, but it's their way of expressing when something is wrong."

A senior member of care staff had been supported to deliver training key topics such as health and safety, infection control and nutrition and a district nurse provided staff with up to date training on people's individual needs such as the management of continence aids and mattress care. New staff undertook a period of induction before they were assessed as competent to work on their own. Staff told us that their induction and mandatory training prepared them for their role. We saw that staff cared for people in a competent way and their actions and approach to their role demonstrated that they had the knowledge and skills to undertake their role.

Staff received regular supervision six times a year and an annual appraisals and said that they were a positive experience and they welcomed feedback on their performance. Staff told us that it made them think about their role and learning needs. One staff member said, "I always have mine with [registered manager's name]. I'm always thanked for the job I do. It's good because everyone [staff] needs to be more aware of their role." Another staff member told us, "I have just prepared for my appraisal. It's the first time I've ever done a self-assessment. I went for middle-ground, I'm sure [registered manager's name] will put me right."

People told us that staff always asked them for permission before they received care. One person said, "They are very good, they tell you what they are going to do. If I don't want them to do it I say so." We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and some people had signed consent for staff to check them at night and others had signed that they did not want to be disturbed. A member of care staff said, "Consent is important, for example, when someone needs pain relief I make sure they understand what they are taking and give their consent before I give them their medicine." Another staff member said, "When giving personal care, I always start by asking what they would like to do today. It's what they want to do; shower or bath."

Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA). An easy read copy of the MCA with pictures and words was available for people who lived in the service.

The 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. We saw evidence that people had capacity assessments for aspects of care individual to them. For example, one person had a capacity assessment to move bedroom on the recommendation of a district nurse to improve their wellbeing.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and 14 applications had been submitted to the local authority and people were waiting on assessments. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People told us that there was always plenty to eat, that the food was good and that they were given a choice. One person said, "Every meal is jolly good, it's very tasty and you get plenty." Another person told us, "You get enough to eat and you get a choice." People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks were provided throughout the day and bowls of fruit were available in the communal areas and we saw people helped themselves to them. We saw that there were information leaflets available on eating and drinking well including advice on food allergies and how to prevent dehydration in hot weather. We saw that alternatives were available to the main menu choices at all meal times, such as soups, hot snacks, salads and sandwiches. A member of care staff said, "Their diet is brilliant. People can have anything they want."

We spoke with the cook who told us that they had a four week menu plan and were currently reviewing the menus with people. They said, "I go round and ask for suggestions. We talk about the foods they enjoyed in childhood, their favourites and make changes to the menu." They added that people had their favourites for the weekend and enjoyed a "fry up" on Saturday and a roast dinner on Sunday. We noted that all dishes were homemade and made with fresh ingredients. The cook told us that Sunday was their baking day and people helped to decorate the fairy cakes.

The cook told us that they catered for people with special dietary needs such as reduced sugar and gluten free and that they made special fruit jellies for people living with diabetes. In addition they told us that they liaised with the local GP for guidance on foods for "treat days" for people living with diabetes or heart disease. We noted that the community speech and language therapist had been involved and had assessed people with swallowing difficulties and had provided the cook with guidance on soft and pureed diets.

The cook told us that some dishes were fortified with butter, cream and syrup to support people at risk of weight loss. Care staff knew what action to take when a person was at risk of weight loss. One member of care staff said, "We monitor their intake on a food and fluid chart and let all the staff know. We notify their GP and district nurse in case they need supplements. And we check their weight."

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, district nurse and dentist. In addition, two people were cared for by the Independent Living Team (ILT). The ILT consisted of a physiotherapist, occupational therapist and advanced care staff that supported a person following a period of ill-health to regain their skills and confidence to return home to an independent life. We spoke with one person on the scheme and they told us, "I'm looked after very well. I'm making really good progress and now walking well with my frame and hope to return home soon." The ILT worked in partnership with staff from Fir Close. A member of care staff told us that they enjoyed working with people under the ILT scheme and said, "I feel I make a difference. I care for people under ILT who have been in hospital after a fall and it's nice to see them go home."

We found evidence of good partnership working between care staff and supporting healthcare professionals and to changes to a person's health and wellbeing were responded to in a timely manner. For example, we observed one person who was receiving long-term care from the community nursing team complained of generalised pain and discomfort. The person's pain did not respond to their prescribed pain relieving medicine and a senior member of care staff called on the district nurse to intervene. The district nurse visited the person immediately and liaised with their GP for a review of their pain relief and this was promptly actioned and requested from the pharmacist.

We spoke with a visiting healthcare professional who told us that they had a good working relationship with the service and care staff would not hesitate to ring them for advice. We saw that a member of the community mental health team had written a letter to the registered manager about the professional attitude of a member of staff and had written, "unfailingly helpful, polite and obliging."

Good

Is the service caring?

Our findings

People told us that they were looked after by kind, caring and compassionate staff. One person said, "The staff are great. We have fun. I know all the staff and they know me." Another person said, "It's all wonderful. I'm very content." We observed staff interacting with people and saw that people and staff had a good relationship and there was a lot of friendly banter. A member of care staff told us of the importance of getting to know people and said, "We build good relationships with them. We talk to them and spend time with them. Talk about their life, their clothes. Go down to their level; sit beside them to talk, to help them eat. We get to know each other." Another staff member told us that they were a "dementia friend" and said, "Everyone needs to be a dementia friend. I've learnt how to speak with people with dementia. We have to live their life, not them live ours. I have learnt how to jump into their world and be part of their world." Dementia Friends is an Alzheimer's Society's initiative to change the public's perceptions of dementia. It aims to transform the way the nation thinks, acts and talks about the condition. Dementia friends can be identified by a forget-me-not badge.

We observed that staff looked after people in a kind and sensitive manner. For example we saw one person who was living with dementia frequently ask staff throughout the day if it was time for breakfast. We saw that staff always took time to talk with the person and demonstrated great patience and understanding of the person's memory difficulties. Furthermore, we saw that care staff responded promptly when a person told them that they had a "sore tummy." The staff member took time to sit with the person and explain what they could offer to help relieve their pain. The person said, "They are always helping me. They do a good job." One staff member told us about a lesson they had learnt about how to respond to people in a timely manner and speak honestly, they said, "I did a dementia course, we discussed the number of times we say to a person "I'll be back in a minute" We were made to sit on our own for two minutes, to know what it is like to be told "I'll be back in two minutes." I felt cut off from people, because I was on my own, I had no one to talk to. It made me feel bad, how does it make them feel?"

We saw measures in place to enable people to be orientated to the day of the week and their surroundings. For example, there was a chalk board with the daily lunch and teatime menus. In addition, some people had a picture outside their bedroom that was significant to them. For example, one person who had served with the Royal Air Force had a picture of a famous aircraft. Furthermore, the signage throughout the service aided people to find their way about. We saw that toilet and bathroom signage was in pictorial and written format.

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. Some people were unable to communicate their needs verbally and this was identified in their care file.

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into the service. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

People were enabled to maintain contact with family and friends and people could receive visitors at any

time. One person's relative said, "We usually get a cup of tea and they always know who we are."

People told us that staff treated them with dignity and respect. One person said, "Yes, they're very good. They are polite. They never grumble and always treat me with dignity when they're doing personal things" Another person said, "The staff are very respectful." We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care. We saw that some people had the key to their bedroom door. This provided a sense of security and ensured that other people could not enter a person's bedroom without their permission. Staff talked about actions they took to maintain a person dignity. One staff member said, "People need to wear their own clothes. I wouldn't want to wear someone else's clothes so why should they?"

We found that supporting a person to live a dignified life and respect their choices was embedded in their care plans. For example, we saw that a person's right to express their sexuality as they wished was respected and how the person wished to be dressed in private.

We saw that small touches made the dining experience a pleasant one at lunchtime. For example, there were fresh flowers picked from the garden on each table and the tables were set with cloths, place mats, cutlery and condiments.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished and most people told us that they were happy. One person said, "I enjoy it here, everyone is very friendly." Another person said, "I couldn't be happier." We saw that some people chose to sit in the lounge, whereas others preferred to spend time in one of the quiet areas of the service or return to their bedroom between meals. There was a coffee lounge that people who lived in the service and their families could use. We noted that four people who had become good friends since moving into the service had chosen to take their meals together in the coffee lounge. One person said, "We are a nice little foursome."

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. Furthermore, people's care files and risk assessments were reviewed each month and changes to their care needs were recorded. For example, one person's immune system was unable to fight infection and their care plan clearly recorded the robust steps to be taken to reduce the risk of the person acquiring an infection from other people, their visitors and staff.

In addition, people were supported to share their life story in a document called "Getting to know you". A member of care staff told us, "They record what they did and what they like to do now. They like to tell you about their job, their children, how many grandchildren they have, and their pets. It's very important to get to know who they are."

Although the service did not have a designated activity coordinator, we saw that people were supported to take part in activities provided by outside agencies. For example, an entertainer visited once a month and someone provided monthly reminiscence sessions. People told us that they were looking forward to a trip out in the service minibus planned for the day following our visit. Care staff told us that some of the best activities were unplanned ones. For example, arm chair exercises where people had used straws and pretended to conduct a band or play drums.

Several people told us that they had enough to keep them occupied without formal activities. One person said, "I do my crosswords and read the papers. I am content." We noted that some people passed their time by knitting, others reading books and magazines and some watching television. However, one person did comment, "There's nothing going on, no cards, no scrabble, no bingo. It must be a boring life for some; at least I've got my knitting."

There was a rummage box with musical instruments in one of the lounges, a reminiscence corner in a quiet area with items for people to talk about and a "bits and pieces box upstairs with dusters and other household items for people to touch, use and talk about. However, we did not see staff support people to access any of these resources.

Where able, people who lived in the service were supported by a member of housekeeping staff to grow salad vegetables and other people were assisted to plant sunflower seeds. The salad vegetables were used

by the service.

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. Some people had adapted their bedrooms to suit their personal needs. For example, one person had a refrigerator in their bedroom and kept a supply of soft drinks and chocolate.

The registered manager had introduced several methods for people who lived at the service and their relatives to give their feedback. For example, the registered manager held a "manager's surgery" once a week, and there was a comments book and suggestion box for people and their relatives to give their thoughts on the service at the main entrance to the service. Staff and people who lived at the service had access to a complaints, comments and concerns policy that advised them to report to the provider, CQC or the local government ombudsman. People told us that they had no reason to complain and could talk with staff at any time. Staff told us that if a person complained to them they would escalate the concern to the register manager or senior staff member on duty.

Furthermore, people who lived in the service were invited to attend regular meetings. We read the minutes from the meeting held in January 2016, that eight people attended. We saw that people were positive about the call bell response times, enjoyed their meals and enjoyed the activities that were provided. However, people had asked if they could go into town more often.

Good

Is the service well-led?

Our findings

We found that there was a positive leadership culture in the service. People who lived at the service and their relatives spoke positively about the registered manager. One person said, "She gets on with everybody here." Another person told us, "She's always been very helpful with us. I know she's helped [name of person] with a lot of things."

Staff told us that they found the registered manager approachable and an effective leader. For example, one member of care staff said, "I know where to go if I have a problem, personal or work. Manager is very approachable and fair. There is good leadership." Another staff member said, "The manager's door is always open, they are accessible."

The registered manager held regular meetings with individual staff groups, such as housekeeping and catering staff and a general staff meeting once a month. Staff told us that they were encouraged to speak the week before our visit and saw that the presentation of menus was discussed and picture menus were to be introduced. I addition we read the minutes from recent day and night care staff meetings. We saw that dignity, mealtimes and shift handovers were discussed.

We found that the registered manager's absence that the senior member of care staff in charge was visible, knew their staff and the people in their care. The people and their relatives that we spoke with knew who the registered manager was, knew that they were on leave and knew the senior member of care staff in charge.

Staff told us that they were a good team and that they were proud to work in the service. One staff member said, "I never come to work thinking it's just another day."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on the use of medicines with people who lived in care homes. Staff were aware of whistleblowing and had access to information about whistleblowing procedures and a contact telephone number for a designated confidential helpline.

The registered manager had the support of two area managers and could call on them at any time. Both area managers were present for feedback at the end of our visit.

A programme of regular audit was in place that covered key areas such as prevention and management of pressure damage, falls and continence. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. In addition, the registered manager undertook an annual quality assurance survey on behalf of the provider that covered all aspects of standards of care in the service including, dignity and choice. We looked at the results for 2015 audit and saw that most responses were positive with the exception of the provision of activities which people found to be inadequate. We saw that the 2016 quality assurance survey had been sent to people who lived at the service and their relatives to be completed.

The provider had an electronic reporting system in place were the registered manager reported all incidents and accidents directly to them. For example, when a person had a fall, the cause of the fall and any action taken at the time were recorded.

The provider's aims and objectives were on display and promoted a high standard of care and the opportunity for people to live life to the fullest.