Prime Care (GB) Limited

Daffodil Lodge

Inspection report

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22 January 2019

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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 21 & 22 January 2019 and was unannounced. This was the first inspection of this service and therefore the service was not previously rated.

Daffodil Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 30 people. Daffodil Lodge Care Home is a large detached building set within a corner plot located in Southport close to the town centre. Daffodil Lodge provide accommodation and care for persons aged from 50 years of age and above, whom require personal care and/or dementia care. Bedrooms were of a single occupancy. Corridors enabled the use of wheelchairs and there was disabled access to the garden. At the time of the inspection 24 people were in receipt of care at the home.

A registered manager was 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.

We viewed four people's care records and found in the main these provided evidence of the care and support people needed though there were some anomalies. Following the inspection, the registered manager undertook a care review to ensure people's support plans recorded up to date and accurate information about people's care and support. The registered manager has also implemented care document and person-centred document training for staff to improve the completion of the care records. The registered manager took prompt action in response to our findings.

People told us they felt safe. Systems were in place for safeguarding people from the risk of abuse and reporting any concerns that arose. Staff had received training and knew what action to take if they felt people were at risk

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act (MCA) 2005 were followed in that assessment of the person's mental capacity was made to protect them. This included applications to the local authority for a Deprivation of Liberty Safeguard (DoLS) for people. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Our observations showed when staff were supporting people they were attentive, caring and respectful in their approach. People and relatives, we spoke with, told us they liked the staff team and they were polite and helpful always.

People and relatives were involved in the planning of their care to support them and kept up to date with matters relating to their health and welfare.

There was enough staff to meet people's needs and keep them safe.

People were offered a good choice of meals and alternatives were offered if the menu choices were not to their liking.

People's medication was safely managed and they received it on time and as prescribed. Staff were trained and deemed competent to administer medicines.

Staff had a good understanding of people's individual care needs and appropriate referrals to external healthcare professionals took place.

Risks to people's safety and wellbeing were recorded to enable staff to support people safely whilst promoting their independence. Accidents and incidents were recorded and an analysis undertaken to look for trends or patterns to minimise the risk of re-occurrence.

People were supported with end of life care at the appropriate time.

Staff received training and support to undertake their job role.

Systems were in place and followed to recruit staff and check they were suitable to work with vulnerable people.

We found the environment to be clean and free from any odour. Staff had access to protective clothing such as, gloves and aprons to support the control of infection.

The premises and equipment were subject to safety checks to ensure they were safe and well maintained. The home was kept in good decorative order and there were some adaptations to ensure it met people's individual needs.

A system was also in place for raising and addressing concerns or complaints and people living at the home and their relatives told us they would feel confident to raise a concern.

Social activities were arranged for people and with the appointment of a new activities organiser the service was looking to improve the social programme which people told us they would like.

There were systems in place to consult with people who used the service, to assess and monitor the quality of their experiences. This included completion of satisfaction surveys. Feedback was limited and there had been no analysis of the findings to support the development of the service.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications.

Governance arrangements included checks on key areas of the service. This helped to maintain standards and to support improvements.

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.

The safety and cleanliness of the environment were monitored effectively.

Staff had a good knowledge of how to safeguard people from abuse.

Medicines were managed safely in the home and administered by staff who were trained and deemed competent.

Recruitment procedures were robust to ensure only suitable staff worked at the home.

Sufficient numbers of staff were available to support people with their individual needs.

Is the service effective?

Good

The service was effective.

Staff received training and support and the service was looking to extend the training programme for staff.

People and relatives were complementary regarding the care and support they received.

People told us they were offered a good choice of meals.

People had access to external health professionals to keep them well and healthy.

Staff understood the principles of the MCA and relevant DoLS applications had been completed.

The home had adaptations and aids to support people's individual needs.

Is the service caring?

Good

The service was caring.

We observed staff treating people with kindness, patience and respect. It was evident staff knew people well.

People and their relatives were involved in the planning of care.

Staff promoted people's rights to confidentiality.

Is the service responsive?

Good

The service was responsive.

People had a plan which recorded the support they needed. Support plans were not always sufficiently detailed, however, following the inspection the registered manager took prompt action to address this.

Social activities were arranged for people and with the appointment of a new activities organiser the service was looking to improve the social programme which people told us they would like.

A complaints' policy and procedure was available for people to refer to.

Staff provided care to people at the end of life with support from external professionals.

Is the service well-led?

Good

The service was well-led.

Quality assurance processes and systems were in place to maintain standards and drive forward improvements.

The service had a committed management and staff team.

People, relatives and staff spoke positively regarding the management of the home and the registered manager's leadership.

People and relatives were provided with surveys to enable them to share their views though feedback was limited at this time.

Daffodil Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 & 22 January 2019 and was unannounced.

The inspection team included an adult social care inspector 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.

The provider was asked to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We contacted the local authority to seek feedback about the service. We used this information to plan how the inspection should be conducted.

Some of the people living at Daffodil Lodge had difficultly expressing themselves verbally. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with seven people who lived at the home, as well as four relatives. We spoke with three carers, the cook, and the deputy operations manager. The registered manager was not on duty however the registered provider was contactable by phone. We looked at the care files of four people receiving support from the service. We sampled three staff recruitment files, as well as staff rosters. We checked daily communications, records and charts relating to people's care, as well as medicine administration records. We looked at staffing which included staff training and support and we also reviewed the home's governance arrangements to help assurance the service provision. This included, for

example, audits, policies and health and safety checks. We walked around the home and observed the delivery of care at various points during the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving care and in respect of the security of the premises. Their comments included, "They (staff) always go to the hospital with me, I feel safer when they are with me until my husband can then come along to take over, they are so kind."

There were processes in place to help make sure people were protected from the risk of abuse. Staff undertook safeguarding training and had access to a safeguarding vulnerable adults' policy and whistle blowing policy to support safe practices. Details of the local authority's reporting procedures were displayed and the registered manager had made referrals to the local authority in accordance with this procedure. Safeguarding referrals were monitored by the registered manager, along with partnership working with the local authority and us the Care Quality Commission (CQC) to provide appropriate responses to keep people safe. Staff we spoke with were aware of the service's safeguarding procedures and were confident to use them

Risk assessments had been completed to help ensure people's needs were met and to protect them from the risk of harm. This included areas such as, falls, mobility, care of vulnerable skin and dietary requirements. Risk assessments were updated to report any change.

The service had a series of internal and external checks in place for the safety of the premises and equipment. This included risk assessments and checks of equipment, water temperatures, fire system, gas and electric supply. These checks showed that the building and equipment were safe to use. Information on how to support people in an emergency was available in the home. There was a fire evacuation plan and individual personal emergency evacuation plans (PEEPS) for people. The PEEPS were reviewed to ensure the information was accurate.

Accidents and incidents affecting people's safety and wellbeing were recorded. These were subject to analysis to help identify any trends and patterns. For people who had a change in their mobility or had suffered a fall, we saw where equipment had been accessed to promote their safety and how risks had been decreased.

The provider had safe recruitment practices to ensure staff were suitable to work with vulnerable adults. This included prospective employees completing application forms and references being sought. Staff had been subject to a Disclosure and Barring (DBS) check, and police checks had been carried out.

People and relatives, we spoke with. told us there were enough staff available to support them with their care. When shifts needed covering due to vacancies or short-notice absence, the registered manager relied firstly on their own staff and then agency workers to cover the shifts. Staff were seen responding in a timely manner to people's requests for support. Staff said the home wold benefit from more staff on a weekend and the deputy operations manager advised us they were recruiting for a kitchen assistant for the weekends to help relieve the pressure on the staff team.

Medicines were administered safely by staff who were trained and deemed competent. Random sampling of people's medicines, against their medicine records, evidenced people were receiving their medicines as prescribed by their GP. All medicines were stored securely and at the correct temperature. Medicine records were clear and people received their medicines as prescribed. We discussed with the deputy operations manager ways in which to improve the recording of creams and painkillers such as, Paracetamol and completion of risk assessments for people who wish to take responsibility for their own medicines. The deputy operations manager stated that these would be actioned. For people who were prescribed medicines on an 'as required' (PRN) basis, PRN plans were in place to support this practice. Audits were completed to provide assurance that medicines were managed safely and effectively. The audits seen were robust and up to date. People we spoke with raised no concerns in the way their medicines were managed by the staff.

The home was found to be clean and staff were using personal protective (PPE) such as gloves and aprons for tasks including personal care and serving meals. This helped to support good infection control practices.

Good

Is the service effective?

Our findings

People and relatives told us their care and support needs were met by the staff. Relatives comments included, "My (husband's) health has improved since living here and mine also through peace of mind. The staff are so good looking after (husband)" and "I like that the staff are quick and attentive, they get (people) washed, dressed and out into the lounge (for those that are able), the staff are engaging with the residents, I have confidence in their abilities to get the job done right."

People were supported to stay healthy. Each person received individualised support with their health appointments. This included referrals to dieticians, speech and language therapists, district nurses, GPs and mental health professionals. We saw where staff had made a prompt referral for specialist support for a person as they were concerned about their mental wellbeing and how this was affecting their health. People's care files recorded health professionals' input and discussions and staff told us how they followed their advice and treatment plans. A person living in the home told us about the visits from their GP and the district nurses and how assured they felt with this medical intervention. Our observations showed good communication between the staff, people they supported and relatives. Relatives said they were informed about any change in their family member's health.

Prior to the inspection we received a concern that there was no staff training. We looked a staff training and saw the registered provider's training programme provided a basis of learning for staff. The training included on-line courses considered mandatory, for example, moving and handling, dementia, fire awareness and safeguarding to ensure staff were skilled to look after people. The training matrix provided dates of attendance of current courses. Following the inspection, the registered manager provided evidence of future training and staff were assigned to complete a long-distance course for behaviours that challenge. Staff undertook formal qualifications in care with most staff having obtained a National Vocational Qualification in Care (NVQ) at Level 3 and 2.

New staff received an induction and one staff member was enrolled on the Care Certificate. The Care Certificate is the government's recommended blue print for induction standards. The Care Certificate induction standards were on file and the deputy operations manager informed us that they and the registered manager were going to complete this to support staff with these standards.

Staff told us they undertook training and received good support from the registered manager and deputy operations manager. This included supervision meetings. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. The deputy operations manager told us staff appraisals would be conducted next month as the home would have then been opened a year.

The service's application of the Mental Capacity Act to protect people's rights regarding decision-making was overall good. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that appropriate applications had been made to the local authority. The deputy operations manager informed us there were no authorisations however they continued to work with the local authority to monitor this. We saw examples of staff supporting people to make decisions, as well as relevant assessments and records of best interest decisions. This included decisions around restrictions, such as the use of bedrails and also where staff support was required when leaving the home.

Where appropriate, people or their relative had signed to indicate their consent and people were involved in the day-to-day decisions which were taking place in relation to the care being provided. We saw staff seeing people's consent when supporting them and people and relatives we spoke with confirmed that staff sought consent as a matter of course. This we saw in respect of support with personal care, medicines and meals.

Staff assessed people's dietary needs and requirements and people told us they were offered plenty of meal choice. A relative told us how much they enjoyed meals served.

There was a four-week menu and staff asked people what they would like from the menu of the day. The menus were however not displayed for people to choose and to enhance the dining experience. The deputy operations manager said they would introduce a menu board or individual menus on the dining room tables. People told us they would like this.

Lunch was a sociable occasion with most people attending the dining room. When people needed support, staff provided this in an unhurried manner. The dining room tables were laid for lunch and people were offered a selection of juices and hot drinks following their meal. People told us how much they enjoyed the lunch and the 'home cooking'. Staff offered people plenty of drinks throughout the day and people had access to a drinks/sweet trolley. Boiled sweets were available to help keep people's mouths moist. Signs were placed around the home to encourage people to drink plenty to help maintain their hydration.

Staff we spoke with were knowledgeable about people's diets. A relative told us their family member liked small meals and staff ensured the portion size was as they liked. Electronic food and fluid charts were completed, as required, and these helped too monitor people's nutrition and hydration.

To promote people's independence, we saw adaptions to the premises had been made and equipment was available to make it easier for people to get around and receive safe support. There was plenty of signage to help people familiarise people with their surroundings. The home was decorated in different colours and furnished to provide some familiarity, such as wallpaper, pictures or ornaments. A relative told us the decor had helped their family member to easily recognise their bedroom.

Good

Is the service caring?

Our findings

Staff were caring, attentive and patient when supporting people.

During the inspection we sat in the lounges and conservatory and saw that the staff regularly interacted with everyone. This interaction was not only to support people with their care but for a 'general chat' with them and their visitors and what they had planned for the day. It was obvious that the staff knew people well and how best to support them. Staff reassured people who were anxious or agitated. They sat with them in an unobtrusive way and stayed with them till they felt at ease and calm. A person said, "The staff sit with me, they hold my hand, that means so much to me."

Staff understood people's rights to be treated with respect and dignity and staff we spoke with demonstrated a genuine positive regard for the people they supported. Staff addressed people by their preferred name and discussed their support in a respectful manner. Staff knocked on bedroom doors and waited to be asked in before entering. People were relaxed in the staff's company and there was plenty of laughter. Staff spent time with people who wished to stay in their room or who were being nursed in bed due to frailty. Staff completed checks to ensure their comfort and wellbeing, along with providing support to people to help maintain their independence. For one person we saw staff checking to make sure they had their glasses and for another sitting next to them on their preferred side to ensure they could be heard clearly.

Visitors arriving at different times of the day and it was evident staff knew them well. We saw staff talking with people about their families and staff showed a genuine interest and good knowledge about people's backgrounds. Visitors were offered light refreshments and could meet their relative in private.

When asking people about whether the staff were caring, there was a very good response to this. Comments included, "They (staff) are fantastic, you couldn't get a better bunch of people if you tried, they really are like family, I settled in very well as the care is so good, we also have some really good fun and laughs, I'm very well cared for", "It's fantastic, your bed is made, you don't have any washing or ironing to do, they treat me really well", "The staff know me really well as they just bring me a black coffee sometimes when I haven't even asked, that's a great service isn't it?" and "I do feel they care a lot as they know I really like pink biscuit wafers they are my favourites so they always ensure they have them for me."

People's needs in relation to equality and diversity were considered by staff and the registered provider under the Human Rights Act 1998. Consideration was given to protected characteristics, for example, age and disability at the assessment stage and when formulating people's plan of care. Staff told us the importance of treating people as individuals and respecting their wishes around how they wished to be looked after.

The home had information to support people's understanding and this included a brochure regarding the service. In respect of care documents this information was made available to people and their relatives. People were provided with opportunities to discuss and agree their plan of care; this also applied to

relatives/and or their representatives when applicable.

Confidential information was correctly stored and protected in line with current governing legislation. We saw staff talking to people about their care, they were mindful of their surroundings and nothing private was shared in communal areas.

Information was available around advocacy services should a person require this support. Advocates are trained professionals who support, enable and empower people to speak up.

Good

Is the service responsive?

Our findings

Individual care files were in place for the people living at the home and we looked at four of these. Although we saw some good examples of detailed personalised support plans, not all the information we were shown contained the level of detail required to provide care based on individual need. This we found in respect of people's nutritional support and mobility. Following the inspection, discussions with the registered manager and the provision of further evidence of where and how this information had been recorded, was made available to the inspector. We were therefore assured that people's needs in respect of their nutrition and mobility was being recorded in sufficient detail to provide support to people in an individualised and safe way. This is reported further under the well led section of this report in respect of record keeping.

We saw people and their relatives (where appropriate) had been involved with drawing up their plan of care and this included personal information, social background, likes and dislikes and preferred routine. A relative said the staff had got to know their family member really well and this had been helped by providing lots of information about them prior to coming into Daffodil Lodge.

During the inspection we saw good examples of responsiveness to people's needs. For example, support for people who wish to take control of their own medicines, support with meals, supporting people with the time they wished to get up and go to bed and preference around male or female staff for personal care. A relative told us how responsive the staff were in that they would call a GP if their family member's condition changed in any way. They said, "The staff are very on the ball."

There were some social activities arrange for people living in the home however people and relatives concurred that the activities on offer was 'not great at the moment' and there was 'not a lot going on'. People told us they enjoyed the entertainers who visited the home but would like more arranged 'in house' to fill their day. A staff member had recently been appointed the role of activities organiser and they informed us about the plans to introduce a more stimulating programme for people. We saw a number of people went out with relatives and one person was attending a day centre each week. The afternoon of our visit people were offered a craft session.

We checked if the registered provider was following the Accessible Information Standard (AIS). This Standard is important as it is there to ensure people who have a disability, impairment or sensory loss get information they can easily access and understand. We saw that information relating to how people liked to communicate was recorded and where people were hard of hearing, staff were encouraged to speak slowly and clearly. There was information recorded around the impact of poor hearing or sight and staff support. The deputy operations manager informed us that information such as, care documents, would be made available in pictorial or large font size to support people's communication on request.

People and their relatives said they would feel comfortable if they had to raise a complaint. No complaints had been received and a complaints procedure was displayed for people to refer to. A relative said, "Oh yes I've not needed to make a complaint at all but I know to quite happily sit down with the manager, (they're) great, (they) pops (their) head in to see us sometimes it wouldn't bother me if I did have a problem as

everyone is friendly, I know any changes would get done if they could."

We saw decisions relating to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had been recorded in some people's care files. Staff supported people with end of life care at the appropriate time, along with the district nurse team, people's GP and other health professionals. Advanced care planning included recording people's wishes on how they wished to be supported at this time. The deputy operations manager and registered manager had completed training for end of life care. This had yet to be rolled out for the staff.

We saw the home utilised assistive technology to support and enhance people's care. This included the use of call bells for staff support and sensor mats and alarms to alert staff when a person may have fallen.

Good

Is the service well-led?

Our findings

A registered manager was in post. People and staff spoke positively about the registered manager describing them as approachable and supportive. A clear line of accountability was in place to ensure that people using the service and staff were aware of who they needed to contact for specific queries. The deputy operations manager worked closely with the registered manager to support the-day-to day running of the service. The deputy operations manager said the registered provider was supportive and receptive when requests were made.

The service had a quality framework which was to oversee standards and drive forward improvements.

We saw a number audits of key areas of the service, for example, monthly care plan audits, health and safety, medicines, staffing levels, infection control, bed rails and weight gain/loss. The deputy operations manager informed us that weekly medicine audits were being introduced to support further developments around the management of medicines. There were no outstanding actions from the audits we looked at and the findings were shared with the registered provider. They in turn completed their own provider audit which confirmed senior management oversight of the service.

Following the inspection, we discussed with the registered manager our findings around where some care information was held. For example, staff referred to a nutritional folder to advise them on people's diets and required support, rather than people's support plans, which had not always been updated to reflect current information. The registered manager has since provided evidence of a care review to ensure people's plan of care records accurate and up to date information. To support this improvement, the registered manager has also implemented care document and person-centred document training for staff, with staff supervision meetings to support the learning. The registered manager took prompt action in response to our findings. We were assured by the measures taken.

Staff were aware of their responsibilities and who they were accountable to. They told us the home in the main was managed well, the managers had an 'open' door policy and they would not hesitate to speak up if they had a concern. Relatives stated their satisfaction for the management of the home. Comments included, "We are so reassured that when we return home at night we are not thinking – well this might happen or that might happen, so we take reassurance from that and "With regards to the communication from the management team this is very good we are notified very quickly if any hospital appointments are needed or opticians have visited they are very responsive."

Resident/relative meetings were not held however no one raised any concerns with us regarding the lack of meetings. The deputy operations manager appreciated this was an area for future development.

In November 2018, satisfaction surveys had been sent out to people living at the home, relatives and staff to obtain feedback about the home. The deputy manager was unable to locate all the surveys and said there had been no formal analysis of their findings. They told us how they had met with a person to discuss their feedback and they were satisfied with the feedback they received. A relative told us they would recommend

the service to another person.

Staff attended three monthly staff meetings. The said the meetings were informative and provided a platform for discussing the service and areas such as, staff training and care planning. Minutes were available of the meetings and we saw where the registered managed had previously raised outstanding staff training as an agenda item.

Policies and procedures were in place to provide staff with information and guidance to support good care. We viewed a number of these which included safeguarding, whistleblowing, infection control and medicine administration. Policies were shared with staff and updated to reflect changes in legislation and to implement 'best practice'.

The registered manager had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations. The registered manager worked with the local authority and other external organisations to support the service.