Care Quality Commission

# Stonehaven (Healthcare) Ltd

# Donnington House

**Inspection report**

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection was unannounced and took place on 11 and 15 May 2015. The inspection was brought forward in response to some information of concern the Care Quality Commission (CQC) received in relation to staffing levels being low.

Donnington House is registered to provide accommodation for up to 36 people requiring personal care. They do not provide nursing care. There is a registered manager in place. 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 living at the home felt safe and well cared for, although there were periods of time where people were left unattended and may not have been fully protected. At lunchtimes there were not always sufficient staff to meet everyone's needs. For example some people needed additional support and encouragement to eat their meals. This support was not always available in a timely way.

# Summary of findings

Activities had started to be planned around people's interests where possible. For example they had recently started a weekly knitting group. There were some paid entertainers who visited the home on a regular basis and staff tried to fit in activities during quieter periods, but this was ad hoc and needed more structure.

Care was planned and being delivered by a staff group who understood people's needs but there were key times when there was not sufficient staff to meet people needs in a timely way.

Risks were being managed and reviewed in line with people's changing needs. For newer people to the service, care planning was taking place over a period of a few weeks. In the interim, staff had the person's pre admission assessment and any care plans and assessments from the funding authority.

Staff understood people's needs and could describe their preferred routines. Health care needs were being monitored and advice sought from GPs, community psychiatric nurses and other health care professionals when needed. One healthcare professional described the service as being ''Receptive to training'' another said ''We are often called in for falls and traumatic skin flaps.''

Medicines were managed appropriately and people received their medicines appropriately and pain relief when required. Staff reported that they felt well supported and had confidence in the management team. Staff felt their concerns, ideas and suggestions were listened to and acted upon. There was a planned training programme covering all aspects of health and safety and some more specialised areas such as working with people with dementia care needs and care of the dying. Staff had regular opportunities to discuss their work and receive support and supervision.

Systems were in place to ensure people and their family had opportunities to have their views heard both formally and informally. Relatives reported they were made to feel welcome and had opportunities to talk to staff and management about concerns or ideas

We found one breach of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report

# 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?**

Requires improvement 

The service was not always safe.

There were not always sufficient staff to meet people's needs in a timely way and to ensure people's safety.

Staff had the right skills, training and experience and they were supported to do their job.

Medicines were well managed and audited to ensure people got their medicines on time.

The recruitment process ensured only people suitable to work with vulnerable people were employed. Staff understood the need to protect people from abuse and knew the processes to ensure this happened.

**Is the service effective?**

Requires improvement 

The service was not always effective.

Consent to care and support was considered and acted upon. Staff understood the importance of upholding peoples' rights and working within the Mental Capacity Act 2005.

Staff demonstrated skills in understanding people's ways of communicating in order to ensure choice and consent was given where possible.

People were supported to eat and drink although some people had to wait for support to assist them in eating their meals. Menus were planned around individual's needs and wishes to support people to enjoy their food and stay hydrated.

**Is the service caring?**

Good 

The service was caring.

Relatives and people living at the home were positive about the staff and their caring approach.

Staff worked with people in a way which showed respect and dignity was upheld.

**Is the service responsive?**

Requires improvement 

The service was responsive to people's care needs but not always their social or emotional needs.

Care and support was well planned and any changes to people's needs was quickly picked up and acted upon.

Some activities were being offered but this was not always consistent due to staffing levels and lack of coordination.

# Summary of findings

People's concerns and complaints were dealt with swiftly and comprehensively.

**Is the service well-led?**

Good

The service was well-led.

There were clear lines of accountability in how the service was being managed, and the provider had introduced a deputy manager post to assist them in the overall running and quality assurance.

Staff, people and their relatives said their views were listened to and acted upon.

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis. This ensured the service was safe and quality monitoring was an on-going process.

# Donnington House

**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 checked 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.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is required to tell us about by law.

This inspection took place on 11 and 15 May 2015 and was unannounced. The inspection was completed by one inspector. There were 30 people living at the service. Time was spent observing how care and support was being delivered and talking with people, their relatives and staff. This included eight people using the service, four relatives and eight staff as well as the registered manager. Following the inspection we contacted four health care professionals for their feedback about the home..

We looked at five care plans and daily records relating to the care and support people received. Care plans are a tool used to inform and direct staff about people's health and social care needs.

We also used pathway tracking, which meant we met with people and then looked at their care records. We looked at three recruitment files, medication administration records, staff rotas and menu plans. We also looked at audit records relating to how the service maintained equipment, records and the building.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

# Is the service safe?

## Our findings

Not everyone was able to verbally share with us whether they felt safe. This was because of their dementia or complex care needs. One person said ‘‘It is very nice here, staff are good, I feel well cared for and safe.’’ Two relatives said they felt the staffing levels had not increased in line with people’s increased needs. One stated ‘‘Although staff are very good, they are very rushed and residents have much more complex needs than they used to which takes more time. There is not enough time to provide proper activities or occupation for people.’’

We had received information suggesting that there were not enough staff to meet people’s needs. We found there were not always sufficient staff on duty to meet the number and needs of people living at the service. For example, in the dementia unit on the first day prior to lunch, we observed a period of around seven minutes when the lounge area had up to 11 people but no staff presence. The senior staff member later told us they needed to go upstairs for a short period to assist with the administering of medicines which require two people to sign for. The two other care staff on duty had been assisting a person with their personal care. During this time, one person was moving around the lounge room trying to move objects and tried to tip another person’s chair further back. Another person kept trying to get up from their chair and was unsteady on their feet. We saw from their care plan, they were at risk from falls and needed close supervision. Lack of supervision even for a short period, placed vulnerable people with dementia at risk. Two healthcare professionals told us there weren’t always enough staff on duty. We heard from one healthcare professional, they were frequently being called in for falls and traumatic skin flaps, which may suggest people were not always being monitored by enough staff. Two heathcare professionals said theire was often a ‘‘strong smell of urine’’, but we did not find this to be the case on the days we visited the home.

The staffing levels were usually seven care staff per morning shift and six per afternoon shift with two waking night staff. The care team were supported by a full time registered manager, one cleaner, a cook and a kitchen assistant. The staffing rota and staff team confirmed there were usually six or seven staff on duty per shift. The registered manager said they had just appointed a deputy manager who will work full time and cover some of the weekend shifts to ensure a senior management presence throughout the week. The registered manager said they did not use agency but tried to cover any sickness or leave using existing staff. They were continually recruiting care staff to ensure they had enough to cover all shifts.

Call bells were being answered promptly on the day we visited, but two people said this was not always the case and one relative commented that in the lounge area it would be difficult for people to alert staff as there was no call bell in their immediate vicinity.

Staff said they worked well as a team but were ‘‘stretched at times.’’ Staff confirmed they sometimes struggled to ensure everyone was assisted with their meals particularly in the dementia unit. We observed one care staff trying to assist two people at once. One person’s meal went cold whilst waiting for assistance and others sat at the dining tables got occasional prompts. There were two people that clearly needed greater levels of support which they did not receive until other people had eaten their meal. This meant their main meal had gone cold and assistance was given for their pudding.

We asked the registered manager if they used a dependency tool to determine the staffing levels, but was told they had a ratio of normally one staff member to five people, but this was not based on any tool, but from previous guidance from former regulators.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of the various forms of abuse and they knew who to report any concerns or suspicions of abuse to. They were confident senior staff would take action if they reported any concerns to them. The registered manager was aware of their responsibilities to report safeguarding issues to the local authority and CQC. Staff had received training about safeguarding vulnerable adults. Where issues of concern or safeguarding had been raised, the registered manager and provider had acted swiftly to respond to these concerns and worked in conjunction with the safeguarding team when needed.

Risks were being managed appropriately, assessments were in place and these identified how to reduce risks. Risk of falls, pressure damage, poor nutritional intake and moving and handling were assessed and kept under review on a regular basis and as people’s needs changed. Where a

Requires improvement

# Is the service safe?

risk had been identified, measures had been put in place to reduce risks. For example, where people were assessed as being at risk of pressure damage, their assessment included clear details about the sort of equipment needed to help reduce this risk. This may include pressure relieving cushions and mattresses as well as regular checks from staff to reposition people so their vulnerable skin areas were not in constant contact with surfaces. However, risk assessments did not include what setting a pressure relieving mattress should be set at in relation to a person's weight. We found two mattresses had been set inappropriately. The registered manager said this was likely to be one of the people living at the home changing the settings.

Medicines were stored safely in a locked medicines trolley within a locked office. They were stored in an orderly and uncluttered fashion. The trolley was clean and free from any excess stock. Systems were in place to ensure people had their medicines at the time they needed them and in a safe way. We observed a member of staff administering medicines at lunchtime and they used the correct procedures as detailed within the service's medicine policy. Staff confirmed they had received training and updates on administration of medication. We observed people received their medications when needed and were asked if they needed additional pain relief where appropriate. Audits were completed monthly on the medication records and stock being held.

There was appropriate recruitment procedures that ensured staff were safe and suitable to work in the home. Recruitment files showed all staff had completed an application detailing their employment history. Each staff member had two references obtained, and had a Disclosure and Barring Service (DBS) check completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services

Requires improvement

# Is the service effective?

## Our findings

People were overall positive about the care and support they received. One person said ''Staff are very kind, they know how to help me, they know what I like.'' One relative said ''We have been very happy with my relatives care. Staff have got to know us and our relative really well.''

People were supported to have their needs met by a staff team who understood their needs and had received training and support to work effectively. Staff confirmed they had been offered training in all aspects of their work and were given opportunities to discuss their role in a one to one supervision session with their manager. New members of staff received an induction process which included covering national guidance on best practice and areas care workers needed to understand such as dignity, respect and safeguarding. Staff confirmed the induction process was comprehensive and included covering aspects of health and safety. They worked alongside another staff member with experience for several shifts to ensure they understood their role. The registered manager said the company were looking at introducing the new Care Certificate which had recently been introduced as national training in best practice.

Care records showed that health care needs were closely monitored and where needed healthcare professionals were called in. Four healthcare professionals were contacted following the inspection and said the service did refer people appropriately and , were receptive to training. Records showed for example, where someone had been monitored for a particular healthcare need, there had been frequent contact with their GP and cumminty nurses. One relative confirmed their family members healthcare needs had been met and they had been kept informed of GP and hospital appointments.

Where people lacked the mental capacity to make decisions staff were guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. Mental capacity assessments lacked detail to show the specific decision the capacity assessment had been completed for. Staff described how they worked to gain consent before any support and care was given. We observed staff talking with people to gain their consent by explaining what they were doing for example, using the hoist to safely move a person. When assisting people to ensure their personal care needs were being met, staff talked calmly and at eye level to aid understanding. Staff then waited for people's response to enable them time to think about what was being asked and to give a response. This ensured people were given the opportunity to consent to their care. This was not always documented as part of the daily notes, but everyday practice observed, showed staff understood and acted to gain people's consent.

Staff had received some training in Deprivation of Liberty Safeguards (DoLS) and understood they should not deprive people of their liberty. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager explained they were in the process of making applications to the DoLS assessors for specific people to ensure they were providing the right care and support in the least restrictive way. Applications were being made in respect of the supreme court judgement made in April 2014. This ruling made it clear that if a person lacked capacity to consent to arrangements for their care, was subject to continuous supervision and control and was not free to leave the service, they were likely to be deprived of their liberty. People at Donnington were not free to leave because all exit doors had keypads to prevent them being opened without the keycode. The keycode was not visable or made availabale to people. Most people would have lacked the capacity to use the keypad. Some people were restricted by the use of equipment such as bed rails, which had been put in place to prevent them from falling out of bed.

People were supported to eat and drink and maintain a balanced diet, although due to staffing levels this was not always delivered in a timely way. We did observe that due to insufficient staffing levels at lunch time, some people's meals went cold and were not reheated.

Systems were in place to ensure those who were at risk of poor nutritional intake, were monitored and supported to eat and drink at regular intervals. Records were kept of the amounts people ate and drank to ensure their intake was sufficient to keep them healthy. People were complimentary about the meals being offered. One person said 'the food is very good, we always get a choice'' Menus showed there was always a cooked breakfast as well as

Requires improvement

# Is the service effective?

cereals and toast offered. There was a choice of two midday meals and a variety of afternoon tea options. The cook knew who needed to have their food at a consistency to meet their needs for swallowing issues for example.

Good

# Is the service caring?

## Our findings

People and their relatives were positive about the care staff provided. One person said 'Most staff are very kind.'' Another person said ''They treat us very well, I have no complaints.'' One relative said they believed staff to be ''Kind and caring'' but felt they did not always have the time to spend with people on a one to one basis.

Staff provided care and support in a kind and compassionate way. We saw examples of staff providing a friendly chat, holding hands or a few words of banter whilst assisting people with their activities of daily living.

Staff worked with people in a way which showed they respected their privacy and dignity. For example making sure people were covered when being hoisted to move from a wheelchair to an arm chair. Staff knocked on people's bedroom doors before entering and checked whether they were ready for support before engaging in providing the support.

Staff were observed to ask people if they were ready for their care and support to be delivered to them. Care plans described to staff how to ensure people were given choice in their everyday lives. For example, care plans around assisting people with personal care stated, people should be offered a choice of what the wish to wear and be encouraged to be as independent as possible.

Staff described ways in which they tried to encourage people's independence such as dressing themselves with minimum support. Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a cup of tea and a late night chat. Staff said that where possible they organised their shifts to accommodate people's choice of getting up and going to bed. They ensured people were given a choice of where they wished to spend their time. One staff member described how one person had previously had a busy work life and was used to fixing objects so they understood their need to wander around and 'fiddle' with objects. Staff also described people's past lives and important family and friend contacts. This showed they were working in a person centred way, thinking about the person as someone with history, not just someone with a dementia type illness.

Requires improvement

# Is the service responsive?

## Our findings

Care plans did not record whether people or their relatives were asked their views on the care and support they received. However in some files it was evident that family members had given detailed information about their relatives past and what was important to them. One relative said they had been asked for their views on how care and support should be delivered, but did not recall seeing a copy of the care plan. Staff were able to describe people's preferred ways of being supported and cared for and knew about people's past history. This showed the care plan information helped staff to work in a person centred way. For example one person was resistive to being supported in their personal care at certain times. Their plan gave instructions for staff to try again later if the person showed any sign of distress. One plan described how someone could become distressed when being assisted to dress and this showed by their level of aggression to staff supporting them. This plan lacked clear instructions about how staff should work in a consistent way to enable them to work with the person. However, staff were consistent in their description about what worked in assisting this person, which showed they knew how to respond to their needs.

For newer people to the service, care planning was taking place over a period of a few weeks and in the interim, staff had the person's pre admission assessment and any care plans and assessments from the funding authority. The pre-admission assessment had usually been completed by the registered manager with the person and their family. This included their usual daily routine, what support they needed and any identified risks the service would need to plan for.

Care records covered people's personal and healthcare needs. These were updated and reviewed regularly by the senior staff with input from care staff. Where people had increased or changing needs, plans were reviewed to respond to these. For example where someone had lost weight, plans had been updated and included more detailed monitoring of their food and fluid intake and discussion with their GP.

There were some activities offered each day. Activities had started to be planned around people's interests where possible. For example they had recently started a weekly knitting group. There were some paid entertainers who visited the home on a regular basis and staff tried to fit in activities during quieter periods, but this was ad hoc and needed more structure. Two relatives said they felt more could be done to ensure people were offered stimulation. One relative said "My relative is lucky because they have lots of visitors, but whenever we come in, it is always quiet, often no TV or music on. They are trying to offer more things, but staff are having to do this when they have spare time which isn't very often from what I can see." One visiting healthcare professional said "I haven't observed any activities taking place, although I do tend to visit on the same day. I have not seen any one to one activities." We did observed people being offered hand massages and nail care on one of the days we visited and staff said they did try to offer people one to one time, such as reading with them. Staff said they would like more time to be able to offer more stimulation to people, but their care tasks needed to come first.

People were supported to stay in touch with family and friends as they wished. Relatives confirmed they were able to visit when they wished and were made welcome. One said "If we have not been able to come in, you can ring for an update on how our relative has been."

The service had a complaints policy and process which was posted in areas of the home. There was also a leaflet which clearly explained the complaints process and gave people the relevant contact details of CQC and the local authority. Residents and relatives meeting records showed people were given an opportunity to express their views about the service. One relative said "We have raised a few grumbles to the registered manager and they have always been dealt with." The complaints log showed that issued raised were investigated and complainants received a response, although this was sometimes verbal and not in writing.

Good

# Is the service well-led?

## Our findings

The service is run by the registered manager who was supported by the provider, Stonehaven, who has seven homes within their organisation. The registered manager had a clear vision and ethos of the service Donnington House provided. This was to provide people with a service where they felt happy and well cared for at all times. The provider supported the manager with regular visits to the service to review the quality of care and complete audits in all aspects of the home. This included auditing training, supervsions, care records, medicine records and records relating to the maintenance of the building. They also provided opportunities for managers of their other homes to meet up and share best practice and learn from things which had not gone so well. For example, one of their other services had already been inspected under CQC's new approach. The learning from this had been shared with other services in the group to help them prepare for their inspections and to highlight areas for improvement across the organisation.

Staff said the registered manager was 'firm but fair 'and described the management approach as open and inclusive. Staff said they felt their views were asked for, and were listened to as part of the quality assurance of the service. There was evidence of regular minuted staff meetings where the running of the service was discussed.

People living at the service were encouraged to voice their views via annual quality assurance surveys and regular resident and relative meetings. Minutes of these meeting showed people were asked their views on what menu changes people would like to see, ideas for activities and discussion about future developments for the service. Two relatives described the meetings as useful and said their views were listened to, although one person felt their views had not always been actioned. For example they said they had raised the issue of staffing levels being low and had been told the organisation was recruiting but did not see that levels had increased in line with people's changing needs.

The registered manager understood their role and responsibilities and had ensured CQC were kept informed of all accident and incidents. Audits were completed on the number and nature of accidents and incidents to see if there were any trends or learning needs for staff. Systems were in place to audit the records, building, cleaning, medicines and equipment. This ensured people and staff were kept safe and any issues were quickly picked up and acted upon.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's needs |