Stonehaven (Healthcare) Ltd

Primrose House

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

This comprehensive inspection took place on 31 October and 6 November 2018. The first day was unannounced. At the previous inspection completed in March 2018 we found staffing levels were not always sufficient to keep people safe. We also found improvements were needed in the recording of medicines and in ensuring the services quality assurance processes were robust.

Following the last inspection, we met with the provider to their review their action plan and discuss what action was being implemented to improve the key questions of safe and well led to at least good. This meeting took place on 30 October 2018 and included discussion about a number of the providers other services.

At this inspection we found there had been improvements in the staffing levels which showed positive impact and outcomes for people living at the service. We saw that the introduction of a new manager and deputy manager had also impacted positively on record keeping and quality assurance audits.

Primrose House 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. Primrose House accommodates up to 30 people in one adapted building. The home is purpose built and set across three floors with bedrooms and communal spaces on each floor. All floors are accessible via a lift. Most people living at this service have conditions associated with old age, frailty and or dementia. At the time of the inspection there were 19 people living at the service.

A new manager has been in place for three months. They had applied to register with CQC. 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.

The new manager together with the appointment of a deputy manager and activities coordinator had made a real positive impact for people. Staffing levels had been increased in line with the needs and increased number of people living at Primrose House. This meant care staff could spent meaningful time with people assisting them with all aspects of daily living. Staff were not task focussed and having more staff on each shift allowed them to deliver quality care and support to people. One staff member described how "We can spend time getting to know people better, taking our time to help them in the morning instead of running around like headless chickens."

Improvements had been made to the governance of the service. This was because the manager and provider had worked in partnership with the local authority quality improvement team. They had produced an improvement plan which was being actioned. Audits and checks were being used to review all aspects of

records and the environment. We have made a recommendation in respect of expanding this.

Staff and people said the new manager was open and inclusive. Staff felt valued and they said they had good training and support to do their job.

Medicines were being managed effectively to ensure people received their medicines on time. People's healthcare was being monitored. Risks were identified and actions put in place to minimise any risks where possible.

People's care and support was being planned in a person-centred way. Plans were detailed and included people's wishes and diverse needs. People enjoyed a wide and varied choice of meals. Mealtimes were relaxed and enjoyable for people.

Recruitment was robust and ensured only staff who were suitable to work with vulnerable people were employed. Staff understood safeguarding processes to help keep people safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice. A recommendation was made to ensure any approved DoLS were notified to CQC.

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.

Medicines were safely managed.

People were kept safe because recruitment procedures were robust and staff understood what to do if they had concern around abuse.

The service was staffed at an appropriate level to safely meet people's needs.

The premises and equipment were maintained to keep people safe.

Is the service effective?

Good

The service was effective.

The environment was clean, well maintained and homely.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

People were supported to maintain their health and wellbeing and their nutritional needs were well met.

Is the service caring?

Good

The service was caring.

People, relatives and professionals said staff showed a caring and compassionate attitude.

Staff understood people's needs, wishes and preferences and ensured choice was being supported.

Staff relationships with people were strong, caring and supportive.

Is the service responsive?

Good

The service was responsive.

Care plans contained information to help staff support people in a person-centred way and care was delivered in a way that best suited the individual. This was work in progress.

Staff were committed to ensuring people experienced end of life care in an individualised and dignified way.

People's social needs were met and they were encouraged to follow their interests. Activities had been expanded to include encouraging people to try new things.

There were regular opportunities for people and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well led.

The management team had begun to establish a strong, open and visible culture within the service. Staff felt valued and their views were listened to.

Quality assurance systems in place to review and assess the quality of service and monitor how it was run were effective.

Accidents and incidents were reported and appropriate action taken, although this was still work in progress.

Primrose 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 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 31 October and 6 November 2018 and was unannounced on the first day. The first day of the inspection was completed by an adult social care inspector and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes. The pharmacist inspector returned on the second day, which was an agreed date, to review how well medicines were being managed.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's Provider Information Return (PIR). This is a form that is completed at least annually. It asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight people. However, some other people were not able to comment specifically about their care experiences, so 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 living with dementia. We also spoke with two relatives. We spoke in depth to the manager, deputy manager, activities coordinator, five care staff, one housekeeping staff, maintenance person and two kitchen staff. We received feedback from two healthcare professionals.

We looked at three care files including risk assessments, care plans and daily records. We reviewed 14 medicines records, three recruitment records and a variety of records relating to the auditing of the environment and quality of care.

Good

Is the service safe?

Our findings

When we last inspected this key question in March 2018, we rated it requires improvement. This was because staffing levels were not always sufficient to keep people safe. We had also found improvements were needed to the way medicines were recorded. Following feedback, the provider increased staffing levels so we did not issue a requirement notice in relation to this. We did issue one in relation to the recording of medicines. The provider sent us an action plan showing how they intended to address this requirement.

At this inspection we found staffing was sufficient for the number and needs of people living at the service. Most days there were five care staff plus a senior carer to work with people across the three floors. At the time of the inspection there were 19 people living at Primrose House. In addition to the care staff team there was a full-time manager, deputy and part time activities coordinator. The care staff were also supported by housekeeping staff and laundry person plus two kitchen staff until 2pm every day. The manager agreed that when more beds were filled the kitchen arrangements would need to be reviewed. She said she had already spoken with the provider's directors about this as at the present time care staff had to spend time preparing the teatime meal and serving it. This meant that one care staff member was in the kitchen for an extended period during the later afternoon. The cook also said that if a kitchen person was assigned to work the afternoon, they could offer a more substantial choice for suppers.

People told us there were sufficient staff to meet their needs One said, "The staff are very good." Another commented "They are all lovely here. They used to have a lot of agency staff but it's good now they have permanent staff." One visiting healthcare professional said they had noted an improvement in staffing levels. "It is much better now, staff are more available to give feedback and the whole atmosphere seems much calmer."

Staff confirmed that since the last inspection staffing levels had been more consistent and had improved. This in turn had helped staff to improve the quality outcomes for people. One staff member said, "We can spend time getting to know people better, taking our time to help them in the morning instead of running around like headless chickens."

Medicines management had improved since our previous inspection. People's medicines were managed and administered safely.

Staff administered medicines and recorded this on Medicines Administration Records (MARs). A sample of MARs showed that people were given their medicines correctly in the way prescribed for them. There were protocols to guide staff on the use of 'when required' medicines. Two people who were prescribed sedative medicines for distress or agitation had personalised and detailed plans available. These included measures to try to reduce agitation, before medicines were considered.

At lunchtime, medicines were administered in a safe and caring way.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including

medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. There was a policy and system in place so that some non-prescription medicines were available to treat people's minor symptoms in a timely way.

Staff completed new charts which had been introduced for recording the application of creams or other external preparations. These included directions for staff on how and where to apply them.

New systems for checking and auditing medicines had been introduced. We saw that actions were identified and completed when appropriate. There were systems for reporting any errors or incidents so that measures could be put in place to reduce the risks of any incidents happening again.

Staff had recently received updated medicines training, and had been checked to make sure they were competent to give medicines safely. There were detailed policies and procedures, and information to guide staff on looking after medicines.

People said they felt safe. One person said "The staff are very careful and make me feel safe. I don't fall. They are attentive and caring."

People were protected because the service had a robust recruitment process. This meant new staff were only employed once all the checks and references had been obtained to ensure they were suitable to work with vulnerable people.

Staff understood what abuse was and who and when they may need to report any concerns to. Staff confirmed they had completed on line training in understanding abuse and that there were policies and procedures they could access if needed. The manager said they were working closely with the adult safeguarding team when needed. She was also going to use some of the local authorities training to help staff gain a more in-depth knowledge of safeguarding.

People's risks had been assessed and where a risk had been identified measures were documented as to how to reduce or prevent such a risk. Risk assessments included risks to skin damage, falls, hydration and nutrition and moving and handling. Where for example a person was assessed as being at risk of developing pressure damage, equipment such as pressure relieving mattresses and cushions had been purchased. Staff were instructed to do regular checks on people's skin conditions. Where people were unable to freely move positions, staff were instructed to ensure regular change of position to help prevent pressure damage. The community nurse team confirmed there was no one currently being treated for any pressure damage.

The manager gave an example of learning from incidents and accidents. This was where she had noted one person had had more than one near miss of almost falling out of their bed. They discussed the issue with the person, their family and the staff team and agreed to move their bed around to make it safe for them. She was also about to have a meeting with the occupational learning lead from the NHS to discuss falls prevention and falls management.

Emergencies were planned for. For example, people had individual evacuation plans in the event of a fire. Regular fire safety checks were being done, including testing of alarm bells. Fire equipment such as extinguishers had been serviced and maintained on an annual basis.

The home was clean and infection control policies and procedures were being followed. Staff had a plentiful supply of gloves and aprons and were seen to use these appropriately.

Good

Is the service effective?

Our findings

People did not directly comment on whether they felt the care and support they received was effective. People however did say "It's very good here - skills very good..." And "Staff know what they are doing." This indicated that staff understood people's needs and were being effective in the delivery of the care of individuals. Staff showed they understood people's needs in the way they talked about how they provided care and support. One healthcare professional said "The staff do seem to have a better handle on patient's conditions and are asking us to get involved appropriately."

Staff confirmed they could access training and support to help deliver effective care to people. The manager explained that she had recently begun to get to grips with making sure staff had one to one supervisions to discuss their role and training needs. She had been making use of the local care homes team nurse educators to assist staff to gain knowledge on health conditions.

New staff who were new to care were expected to complete the care certificate. This is a nationally recognised course which ensures staff have the right competencies to work within care. Staff were being encouraged to gain nationally recognised certificates in care as well as complete their mandatory training in all aspects of health and safety.

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. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

The Care Quality Commission (CQC) monitors the operation of DoLS and we found the home was meeting these requirements. The registered manager was aware of their responsibilities in relation to DoLS and had made appropriate applications if they needed to restrict a person's liberties. Some of these had been authorised by the DoLS team. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions.
The manager had reviewed the DoLS expiry dates and who else she may need to make applications for. There had been one authorisation since the manager took over. She had not realised she needed to notify CQC of these. She agreed to add this to her check list.

People were supported to ensure their nutritional and hydration needs were met. Where people had been

assessed as being at risk of poor nutritional and or fluid intake, staff closely monitored their daily intake. People's weights were monitored weekly and monthly and where weight decrease had been significant, the staff team referred the person to their GP. Some people had been prescribed supplementary drinks to help maintain good calorie intake. The kitchen staff were aware of how to fortify meals to ensure additional calories were added to those who needed them. For example, cream and butter being added to mashed potatoes. The kitchen staff were also aware of those people who require restricted diets such as diabetics and any allergies, likes and dislikes. One of the cooks said they needed to ensure this was recorded as their number had increased.

People were complimentary about the meals being offered. Comments included "The food is as good as the best you can get of mass catering. There is always a choice if you want something else. I have no problem with the food. I always eat in my room as I don't really like the chatting across tables at meals." And "The food is very good and there is sometimes a choice but we can always ask for something else anyway. They are open to suggestions."
Our observations showed mealtimes were relaxed, people were offered a choice and staff were available and on hand to support where needed.

It was clear from daily records, speaking with people and staff that their healthcare need was being met. People said they could ask to see the GP at any time. There were regular visits from the district nurse team for people who required ongoing nursing care. People were assisted to hospital appointments and arrangements were in place if they needed to see the optician and chiropodist. At the time of pre- admission assessment people's needs, wishes and choices were recorded where known.

Primrose House was designed and built as a care home. As such the design and layout were suitable for people with mobility issues. For example, the corridors and doorways were wide to accommodate wheelchairs, hoists and mobility aids. Clear signage had been used to help people orientate around the room and find rooms such as toilets and bathrooms.

Good

Is the service caring?

Our findings

People, visitors and professionals all said staff were kind and caring in their approach. One person said, "They help with my personal care and are very considerate and gentle" Another said, "The staff are all very nice, they are helpful, very kind, I like them."
One relative said "The staff are very capable, they know what they are doing. They are kind and patient with people and this is very important." One healthcare professional said "Staff do show kindness and caring towards people here. They check on those in their rooms, provide extra blankets. They seem very attentive."

Our observations showed staff displayed caring attitudes and acts of kindness throughout the day. One staff made sure people were comfortable where they were sitting for example, offering blankets. Another staff member spent time asking people how they felt and whether they would like to help decorate the room for Halloween. There was laughter and fun exchanges between staff and people. The atmosphere was relaxed and calm. It was clear people felt comfortable chatting with staff and asked questions about their day and their families.

Staff had developed strong bonds with people and knew what and who were important to them. They also understood people's nonverbal communication. They picked up when someone became slightly agitated with another person and distracted them to help with decorating the room.

People's privacy and dignity was upheld. We saw care staff knocking before entering people's rooms. Staff were able to describe ways in which they provided personal care ensuring people's privacy and dignity was taken into account.

People's rooms had family mementos and personal touches such as photographs and books and ornaments, giving them a homely feel. People and relatives confirmed they could visit at any time, were made welcome and offered refreshments. People could choose to see their friends and families in the privacy of their room or a communal area if they wished.

People were afforded choice about where they wished to spend their time and staff encouraged independence as far as possible. Care plans described what personal care people could do for themselves and what support they needed. This helped to give people their independence.

Staff spent time explaining what care tasks they were doing, for example when hoisting someone into an armchair. They did this with patience and spoke to the person at each stage to ensure their comfort and explain what they were doing.

The service had received a number of compliments and thank you cards which highlighted how pleased families had been with the care their relative had received. Comments included "The care mum received whilst she was with you was second to none. The compassion, kindness and understanding means so much" And "Thank you for your patience and kindness." One relative had recently nominated the service to a local radio station for an award for the kindness showed to their family member. The crew from the radio

station arrived with a platter of sandwiches for 'feel good Friday' to thank the staff for the support given to people in their care.

Good

Is the service responsive?

Our findings

People said staff were responsive to their needs. Comments included "They help me when I need help. They are very good." One relative said "It's a weight of my mind that he's here – I was heading for a nervous breakdown."

In previous inspections we have highlighted that people were not always meaningfully engaged and activities had not always considered people's needs, wishes and preferences. Since the last inspection this has improved. This is because there were now more staff available each shift. This impacted positively on the amount of time staff could spend with each person. Staff agreed that since the increase in staff, they could provide quality care and support. One said, "We are not rushing around, we can chat to people, we can give people more choice and we can help people when they ask, instead of having to say, could you hang on I will be with you soon." In addition, the service has employed an activities coordinator who works across both the provider's services as they sit side by side. The activities person showed a great deal of enthusiasm for her role. She had introduced a number of new initiatives which included more engaging activities for people to try. For example, they had organised regular visits by school children who came in weekly to read, sing and spend time with people. This was a huge success for most people living at the service. They had also introduced more craft sessions and regular games, quizzes and paid entertainers.

On the day we inspected children came from a local school to spend time with people living at Primrose House. The staff and people had decorated the home with Halloween decorations. We heard from the activities person how she had arranged for her children and their friends to visit later in the evening to show their costumes. They had purchased sweets for people to take part in 'trick or treating.'

People's care and support was well planned. This was because there were clear care plans which instructed staff how to best support someone with their personal care, emotional and healthcare needs. Staff confirmed they used plans to help them understand people's needs. Plans ensured people had person centred care because it gave good details for staff to understand their likes, dislikes and preferred routines. Plans were electronic, although paper copies were made available in case of systems breakdown

The manager explained that wherever possible she or her deputy would complete a pre- admission assessment of any potential new people prior to them being admitted. This information would then be used for the basis of the care plan. As staff got to know the person better and their wishes and routines were discussed, the care plan was revised.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included where staff needed to consider people's sensory or hearing impairment. Staff were able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Areas of the service were sign posted with pictures, for example toilets, to help people find their way.

The service had a complaints process with written details of who people could make their concerns and complaints known to. The provide information return stated the complaints process was behind each bedroom door so "service users or families can access this, relatives encouraged to speak to manager if any concerns or issues that arise." Complaints log showed complaints had been responded to in a timely way and complainants were given a written response with actions taken to resolve any issues identified.

People were asked if they wished to record their end of life wishes as part of their care plan. Staff worked with the GP and district nurse team to provide end of life care when needed. Some staff had received training via the hospice on end of life care. Thank your cards showed families had been satisfied with their relatives end of life care. One said, "Thank you for making their final days as good as they could be and for supporting us as a family."

Good

Is the service well-led?

Our findings

When we last inspected this key question, we rated it requires improvement because the systems and audits the provider had were not always effective in ensuring care and support was being reviewed comprehensively.

At this inspection we found improvements had been made and audits in relation to the way records were being completed, the maintenance of the home and how care was being delivered were all being audited. The provider used a mystery shopper each month. Someone called the home to make an enquiry and whoever answered should ensure they provide the right information. The manager said she had worked with staff to ensure they did answer phone calls correctly and gave callers detailed information. This meant for the last few months the service had past the mystery shopper test. Staff were rewarded with a financial bonus.

Audits were completed by the manager each week and month and covered care plans, risk assessments, training and environmental audits. Falls monitoring was being completed but would benefit from a more comprehensive oversight and review. The manager was due to meet with the occupational therapist educator to discuss falls audits.

We recommend audits and checks on the environment include equipment such as air wave mattresses as these were not currently routinely recorded as being checked.

The service had a new manager since the last inspection. She was about to be interviewed as part of the registration process with CQC. People, relatives and staff all spoke highly of the new manager. Staff said her approach was open and inclusive. One healthcare professional said, "Things have really improved with the new manager."

The service had worked in partnership with the local authority quality improvement team to produce and action a service improvement plan. The staff were also working more collaboratively with the community nurse team and GP's to resolve and/or improve people's health.

The provider information return stated "Directors visit the home every month and audit and support where needed. Care liaison manager visits every two months but is always contactable in between time for support if needed." The director was now providing a written report on their visit. Previously we identified that this was not happening.

Since the last inspection, the provider had added in an additional management post of deputy manager. This had helped to ensure reviews and audits were being kept up to date.

The provider used various ways to gain the views of people and their families. This included annual surveys, meetings and one to one discussions. There was evidence of staff meeting with people to discuss their ideas and suggestions for improvement. For example, the sorts of activities they would like to do and any

suggestions for their menu options.

The manager understood their responsibilities to act in accordance with regulation and to report any significant events and notifications. She had actively sought advice from the inspector prior to the inspection. She was part of a local managers network to help improve practice and share best practice.

The rating from the last inspection report was prominently displayed in the hallway of the service and on the provider website.