# Stonehaven (Healthcare) Ltd

# Primrose House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | Requires Improvement |

# Summary of findings

## Overall summary

Primrose House was registered in October 2016 to accommodate up to 30 older people. This was the first inspection since being registered. The inspection was unannounced and took place on 8 and 14 December 2016. We decided to complete this comprehensive inspection in light of receiving some information of concern and other safeguarding concerns which were being investigated by the local authority. Concerns included some people's care needs not being met, lack of activities, poor management of falls, lack of personal care, staffing levels not being sufficient to meet peoples needs, management of medicines and pressure damage to skin. At the time of our inspection there were 11 people living at the service and one person who had been admitted into hospital.

Primrose House is a newly built service which sits alongside another home run by the same provider. Primrose House and the sister service Donnington House are run by the same registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The home also had a deputy manager who was fully involved in all aspects of the home.

Risks had not always been fully assessed to help keep people protected. Where people were at possible risk of developing pressure damage, there was not always a risk assessment with actions for staff to follow to reduce such risks. Care plan information was vague and did not fully describe what equipment was needed in helping to prevent pressure damage.

Where people were assessed as being at risk of poor fluid intake, the records were not always completed so there was limited information to demonstrate whether they had been supported to maintain a healthy fluid intake.

Care plans gave basic information and were not person centred. For example, they did not give any information for staff to help understand what the person's life history was and what their preferred routines and wishes were. Without this essential information, staff would not be able to support people in a person centred way. One newer member of staff described how they were asked to help get people to bed at a certain time. They said they were aware people were settled and did not show any indication they wished to retire to their rooms at that time. The member of staff did question this practice but was told they should follow instructions. We fed this back to the registered manager and deputy manager who said there was no set time for staff to help prepare people to get ready for bed. They would investigate this issue and ensure all staff were aware that people should be assisted as and when they wanted to retire to bed. Other staff we spoke to knew that people could get up and go to bed whenever they liked.

As a new service in a new building with a new team of staff, the registered manager and deputy felt they may have tried to admit too many people within too short a space of time. They said this had been complicated further by several people displaying more complex needs than their initial assessment had indicated. This

led to staff being overstretched trying to ensure people with complex needs were kept safe. They agreed that this had meant for a short period, that people with less complex needs may not have received the care and support they always needed. For example allowing extra time to ensure staff could go back to people who were initially reluctant to accept personal care. We found there were sufficient numbers of staff on during the inspection. The registered manager and deputy said they had learnt from this difficult period that they needed to 'take stock' and not admit any more new people until they had all their records, plans and training of staff up to speed.

Staff described how on occasions, for some people they needed to use safe holding to ensure they were able to complete personal care without the individual or staff being harmed. Staff had not received training in such restrictive measures. Advice from the mental health team had been requested for guidance with people's care.

Restrictions such as pressure mats, bedsides and locked doors were being used to keep people safe. The deputy manager said she had been making some urgent applications to the local authority for Deprivation of Liberty safeguards (DoLS) but this was not documented within care plans. Staff were not always aware of who had applications pending. We observed one person asking to leave and trying to get out of the patio doors. They did not have a DoLS authorisation or application pending. The deputy manager said the person was the next on the list and agreed they would make an urgent application as soon as possible. This had been completed by the second day of our inspection.

Some newer staff were not aware of which topical creams should be applied to which parts of people's bodies. The service had a form and body maps to guide staff but these had not been used. The deputy manager said she would ensure these were in place for each person by the end of the day. They said they would make sure staff had access to this information within the care and daily notes they used on each floor for easy and quick reference. By the second day of the inspection these were in place.

There were enough staff with the right skills for the current number of people living at the service. A dependency tool had not been used to determine the staffing levels. The registered manager assured us, this was being kept under constant review in line with people's changing needs. She gave the example of one person whose needs suddenly increased and she decided in order to keep them safe whilst an alternative placement was being sought, that they would provide one to one staffing for this person.

People and their relatives described staff as caring and kind. One relative said that although there had been some initial 'teething problems' they were ''overall satisfied with the service. Staff really good.'' Another visitor said ''I can't fault the service, staff are wonderful. I can visit when I like and am offered a meal if I wish, which they don't charge me for. Building really lovely and care staff brilliant.''

During our visits people said they were happy with the meals offered. We observed lunchtimes to be relaxed and social occasions. Staff assisted people and encouraged those who were reluctant to eat to try some of their food. Staff engaged with people in a kind and respectful way. People were offered a variety of choices throughout the meal such as what drinks they would like and whether they wished to have more food.

There were quality assurance systems in place but these were not fully effective.

There was a strategy meeting held on 13 December 2016. The registered manager and deputy manager attended. An action plan was agreed, which included agreeing not to admit any more people until the New Year or until better systems were in place. The management team based at the home accepted the findings of the meeting. The local authority quality assurance team would provide support to the home. CQC will be

meeting the provider in January 2017 to discuss their action plan and will be visiting again within three months to ensure that all requirements are met. The registered manager and deputy manager have kept CQC up to date with all matters requested following the inspection.

There are five of breaches of regulations. You can see what action we took at the end of the report.

## 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**

Not all aspects of the service were safe.

Risk was not always managed that meant some people had not received the care they should have done

Some aspects of medicines management needed improvement. Records were not consistently kept up to date.

There were enough staff to ensure people's needs were met

There were safe recruitment processes in place, meaning that staff were suitable to work at the home

### Is the service effective?

**Requires Improvement**

Not all aspects of the service were effective.

Not all staff understood the Mental Capacity Act 2005 ( MCA) and had not ensured that best practice was followed

Staff showed they had skills and knowledge to provide care for people, but some staff needed updates to ensure they delivered effective care.

Staff knew how to access health care professionals when someone became unwell

People enjoyed the meals provided at the home

### Is the service caring?

**Good**

The service was caring

Staff were caring and kind to the people living at the home.

People were treated with dignity and respect

### Is the service responsive?

**Requires Improvement**

Some aspects of the service were not responsive

Assessments of some people moving to the home had not identified some aspects of care. This meant the staff were unprepared to care for a number of people with complex needs.

Care plans were not always detailed enough to describe the person's needs, although this had improved by the second day of the inspection. There were limited social activities provided at Primrose House.

The registered manager was responding to complaints and relatives said they knew how to make a complaint

## Is the service well-led?

**Requires Improvement**

Some aspects of the service were not well led.

Too many people had been admitted to the home in a short space of time with complex needs. Despite this, admissions had not stopped and the situation deteriorated.

Quality assurance systems were not fully embedded at the home.

The management of the home are actively working with external agencies to improve the management of care at the home.

# 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 8 December and 14 December 2016. The first day was unannounced and completed by one adult social care inspector . The second day was completed  an inspection manager.

As this is a new service there was limited information held by CQC. We reviewed the information gathered from the registration team, the service user guide and Statement of purpose. We also reviewed information received from people who had concerns about the service.

During the inspection we spoke with most of the people living at the service and with two in detail about their experience of living at the service. We spoke with seven visiting relatives or friends. We also spoke with eight care staff, the registered manager and deputy manager.

We reviewed four care plans, food and fluid charts, medicine records, risk assessments, three recruitment files, some audits and staff rotas.

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

People were not always kept safe because risks had not always been fully assessed or monitored.

For example, one person who had recently been admitted to hospital as their health had deteriorated had developed pressure damage to their heels and sacrum. The daily notes of this person indicated that when they were first admitted into the home, they were fairly mobile and ambulant but in the two days prior to their admission into hospital, they had shown signs of physical deterioration and spending longer periods of time in bed. This would have increased the risk of developing pressure damage. Despite this noted change in their needs, a risk assessment had not been completed to guide staff about how best to support the person to minimise the risk of them developing pressure damage. Their care plan indicated they required pressure relieving equipment, but this was not specific and did not inform the reader what this equipment was. We were informed the person used a pressure cushion for sitting out of bed and the mattresses within the service were all of a high specification to help reduce pressure damage.

Where people were assessed as being at risk of poor fluid intake, the records were not always completed. For example, where people were being monitored for their fluid intake, there was no guidance as to the optimal amount staff should aim to encourage people to drink. Without this information to guide staff, it was difficult to see how they were monitoring people to maintain good health. This meant people were at risk as there was limited information to demonstrate whether they had been supported to maintain a healthy fluid intake.

Some newer staff were not aware of where topical creams should be applied on people's bodies. The service had developed a topical creams chart with a body map to help guide staff, but these had not been implemented. The deputy manager said she would ensure these were in place for each person by the end of the day. They said they would make sure staff had access to this information within the care and daily notes they used on each floor for easy and quick reference. By the second day of the inspection these were in place.

Staff described working with some people with complex care needs who were resistive to care. In order to keep the person and staff working with them safe, people had needed to have their hands and arms held. Staff had not received training in safe hold techniques, and therefore may not be doing this in the safest and most appropriate way. We fed this back to the registered manager and deputy who agreed they needed to source this training for staff. On the second day of the inspection the deputy manager and health care professional from the care homes team discussed this issue. They had requested via GP for a community mental health nurse to assess one person who was resistive to receiving personal care. They would then establish whether what specific training was required for staff. The care plan for this person had been amended to describe different ways of managing with behaviour was challenging.

Not all aspects of medicines were managed safety. A recent safeguarding concern had highlighted that someone had not had all their medicines given. This had been investigated by the local autroity safeguarding process. There had not been a full audit of medicines since the home had opened. Staff

recorded on the Medicine Administration Charts (MARS) when medicines arrived into the home, but on two records we looked at staff had not written down the incoming amount of tablets. This meant it was difficult to audit whether the correct numbers of tablets were left. One person had regular blood tests because of the type of medicine they were taking. There were records in their notes from the community nurse confirming they had taken the blood test. However, on receiving the results, the care staff had not been requesting a copy of the persons required dosage, and instead had been rewriting on a sheet which was a month old. This presented a risk that the prescription may have been changed but there was no record of this. By the end of the second day of the inspection, this had been rectified and it had been agreed with the GP that they would always send a fax to the home every time when new blood results were in. All staff who administered medicines had received training. However, the training matrix showed that four members of staff had not received updated medicines training.

Staff were generally visible in the lounge areas, but during lunch on the second day there were two brief occasions where staff had left the room when people were eating. Although no one had been identified at risk of choking, the deputy manager agreed this should not have happened. They said this should not have happened and were going to remind the staff . They were also going to to address this concern with all the staff at the next team meeting on 22 December 2016 .

These issues identified above are a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a locked trolley containing medicines, which was attached securely to a wall. There was also a separate medicines room, with two fridges. Temperatures were being monitored every day. There was a separate cupboard for any medicines which needed secure storage, but at the current time no one was prescribed such medicines. We observed one senior care worker administering medicines. They followed correct procedures, checking if people wanted their medicines and always signing the medicines administration records (MARS) after someone had taken their tablets. MARS had any allergies recorded on them and an up to date phot of the person. One person was receiving covert medicines. This had been in consultation with the GP, for one time of the day to help them with their sleep at night. Another person had their medicines changed. This had been agreed with the GP on the telephone. This was written into the person's care records and altered on the MARS. The GP had agreed for the community mental health nurse to visit them to assess their behaviour.

The registered manager informed us after the inspection that all people who used a specialist air mattress had a turning chart. Night staff had to check on people at least two hourly and also to check that the mattress was set at the right setting according to that person's weight.

There were sufficient staffs on each shift with the right skills and experience to meet the needs of people currently living at the service. Six of the current staff group had worked at Donnington House and five staff were new. On the first day of the inspection, there were 11 people living at the service and one additional person had been admitted into hospital. On each shift throughout the day there were five care staff which included a senior care staff member. On some afternoon shifts there were six care staff. Through the night there were two waking night staff. The service was based over three floors with bedrooms and lounges on each floor. Because the occupancy was only at just over a third, the service was being run over two floors, which effectively meant for the day time there were two care staff per floor plus one senior care staff member working across both areas. One relative said "There are always enough staff. [ person's name] is under constant care".

Staff said with the current people they were supporting, they felt there were enough staff available to meet

their needs. Relatives agreed there appeared to be enough staff available to meet people's needs. One relative said ''Yes there are always staff around if you need them.'' The registered manager said there was a dependency tool that was used at Donnington House, but that it had not been used for Primrose House. The Quality Assurance team ( from the local authority) were going to share a tool with the home. Staff said agency staff were used if there was staff sickness.
Staff described how recently they had felt stretched because of the increased complex needs of two or three individuals. These people had initially settled well into the service but had quickly developed ways of expressing themselves which presented as a challenge to staff. This meant their time was taken up trying to ensure these few people were kept safe. For example, one person who was able to wander out of the building, was aware of key pads numbers, but had placed themselves at risk at times not showing an awareness of needing to have road safety awareness, when they left out of the front door. Another person had become increasingly resistive to care and appeared unsettled and spent periods of time wandering into other people's rooms. The initial assessments of these individuals did not indicate they may present with behaviour which required more intensive staff support. The management team recognised they were unable to meet such complex needs and have decided they would not admit any new people until records were up to date.

Before staff started work at the home all proper checks had been undertaken to ensure they were suitable to work. The application form contained the correct information as required by law, although the space to include all previous employment was limited. The files also contained certificates of all training they had undertaken

Staff understood what might constitute abuse, what signs to watch out for and who they should report any concerns to. Newer staff said they were beginning to cover the safeguarding processes as part of their induction, but said they would always refer any concerns to their seniors and were confident these would be followed up.

Accidents and incidents were reported and reviewed to identify ways to further reduce risks. They were monitored to identify any trends related to accidents/ incidents, falls, complaints and medication errors. The deputy described how for example, having reviewed a complaint they then saw there had been one medicine error and a few times when an individual had been asleep when their medicine was due to be administered. They had spoken to staff about the need to check with the GP about times of medicines administration, if there was a regular pattern of someone not being awake for the medicine. Where a staff member had missed one person's medicines, they had received an additional supervision and had been asked to complete a workbook on safe administration. The registered manager also said they would be completing weekly medicines audits which would include ensuring staff competencies were being checked.

We looked at the care plan of one person who was at risk of falls. This had been updated on 10 December 2016 to show they were at risk. Staff were guided to supervise them when mobilising.

Each person had a personal emergency evacuation plan in case of emergency situations. These were signed and dated. The building was new and all the relevant certificates were in order relating to gas, electricity, the lift etc. There were contract servicing arrangements in place.

There is a new initiative in North Devon, where the care homes team will be working in partnership with a pilot group of care homes when someone has a fall. The intention of the scheme is to provide help and advice as soon as someone has a fall who would normally be admitted to hospital. Hopefully this will mean a reduction in admissions to hospital for people. Primrose House had been selected to be part of this pilot. They were looking forward to working closely with health and social care professionals to prevent harm

from falls and avoid hospital admissions. In the meantime the deputy manager had spoken to an Occupation therapist to assess how falls were currently being managed.

Requires Improvement

# Is the service effective?

## Our findings

Two people were able to say how their care was being delivered in a way they preferred and that they were offered choices. One relative said ''I can definitely say the staff offer everyone a choice of meals and drinks.'' Staff worked in a way which ensured people had choice throughout their day and records showed that staff gained people's consent before providing care and support. Staff talked about ways in which they offered people choice, for example what time they wished to get up, what they wished to wear and where they chose to spend their time.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People at Primrose House had consented to their care where they were able to make an informed decision. Where people could not make an informed decision, based on a lack of capacity to do so, an assessment of their capacity had not always been undertaken. It was not clear from care plans whether there had been a mental capacity assessment and if there had, whether this was decision specific. There were examples of where decisions had been made in people's best interest, by people who knew them best, but this was not always recorded as a best interest meeting. For example in the use of bed rails, cover medicines or pressure mats to keep people safe.

After the inspection the registered manager sent us copies of some MCA documents. These showed where staff were making decisions for people in their best interests. These included where someone was at risk of falls, refusing to take medicines or resistive to receiving personal care. These needed more detail in some places, e.g. to record steps staff would take to try and gain consent before giving medicines covertly. The deputy manager was in the process, following the inspection to ensure all people had specific MCA records where required.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberties Safeguards (DoLS). The deputy manager said they were in the process of applying for urgent DoLS for two people, but where there was one other person who was clearly asking to leave and trying to get out of the patio doors. They agreed an urgent application would be made for this person. There was no indication within care plans about who the service had applied for such safeguards. As such staff had some limited knowledge about the MCA and were not certain which people had applications pending and why.

These issues identified above are a breach in regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff was given time and opportunity to learn from more experienced staff, spending time shadowing

staff, before being part of the staffing rota. Staff confirmed they spent three shifts watching more experienced staff before they were included as part of the rota. They were also given a tour of the building, shown the fire safety procedures and given a moving and handling practical session before they were able to offer care and support. Newer staff said they had been given work books to begin the Care Certificate. The care certificate is a national training programme in best practice which was introduced in April 2015.

Staff said they had completed training. The training matrix showed that some staff needed updates, such as medicines training. Other training undertaken included was infection control, challenging behaviour, dementia awareness, nutrition, health and safety. Since the inspection the registered manager has informed us they have booked more training from a local pharmacist for medicines updates. One care worker was completing a 16 week course in dementia at the local college, which they were really enjoying. They had also completed training first aid, manual handling, NVQ3, safeguarding and the Mental Capacity Act. One care worker told us what the training had taught them. "Their needs are different and you need to work out how to care for them. You must give eye contact, have an open body posture, ask open questions, try to engage with their past, and make it relevant for them. I like learning"

People were offered a variety of meals to suit their tastes and promote their health and well-being. People said they enjoyed the meals. One family described how their relative had come to the service being underweight but had gained weight and was enjoying the food being offered. The meals are currently cooked at their sister service next door and bought across on a hot trolley. People were offered a choice of two main meals. The kitchen did not contain a list of likes and dislikes, although there was a list of who was on a special diet. On the second day of our inspection, the main meal was lasagne or grilled fish with a garlic butter sauce. For pudding it was stewed apple or bakewell tart.

There were plenty of drinks available for people on both days of the inspection. When the home opened they decided to put everyone on a fluid and food chart. They recognised that they needed to assess who was more at risk of not eating or drinking enough, and ensure that those people were monitored. The charts we looked at on the second day were completed and up to date.

Staff were aware of checking for signs that someone's' health may be deteriorating and knew for example the signs and symptoms of a possible urinary tract infection. They had test kits available to check for this and refer quickly to the GP if needed. Care records showed people's health was being monitored and where one person had shown signs of becoming ill, emergency services had been contacted. People often retained their own GP when they moved to the home, and there were three GP surgeries that were used. Opticians visit every six months and the chiropodist every six weeks. Community nurses and physiotherapists visited the home on a regular basis.

One relative said ''The staff are very on the ball and know when to call the GP. I have no worries on that front.'' Another said ''[person's name] needed a specialist bed and where they were before would not supply one. Here they have been very good at making sure they have the right equipment in place. They need a longer bed and a specialist mattress due to having a back problem.''

The home is purpose built and provides accommodation for 30 people. All bedrooms are ensuite with a shower. Family members were very happy with the standard of accommodation. There are three floors, and each floor has its own lounge/ dining room. This meant that people live in smaller units, with staff allocated to each floor for their shift.

Good

# Is the service caring?

## Our findings

One relative said ''We have no concerns about staff; they are all lovely and very kind. We are always made welcome.'' Another added "[ person's name]is always well presented. I think the staff are great. They are very kind and patient. Staff have been very helpful here" "The care is very good, without a shadow of a doubt. They are always ready to listen". "I do feel they have their best interests at heart".

Our observations of how staff supported people showed staff had compassion and patience. They checked people were comfortable and offered support at lunchtime for people who were reluctant to eat. At one meal we saw staff chatting to people in a friendly and inclusive manner. It was clear staff were developing strong bonds with people living at the service. One staff member said ''I am quite new to care work, but I love it. I enjoy making someone smile, making a difference. I treat people how I would want my granny to be treated". Another care worker said "You must treat them like your own mother; everyone has their own ways and quirks." This care worker recognised how difficult it was for one person who lived at the home who wanted to be at their own home.

Care staff treated each person with dignity and respect. They had time to sit down and talk to people and engage with them. Because the home was divided into three units, lounges were small and there was a warm and homely atmosphere. Staff explained how they gave people choices throughout the day. People could get up and go to bed when they chose. People were offered choices at lunch time, whether they wanted tea or coffee etc.

We were not able to speak to people about how involved they were in decision making. Many of the people at the home are living with dementia. On a day to day basis, people were being involved as much as they could; for example there was a Christmas party during the week. The registered manager explained that each person would be asked if they wanted to go over to the party at Donnington House. She knew that one person would not want to go, so they would be able to stay at Primrose House.

Visitors told us they could visit at any time they wished to. They said they were made to feel very welcome and part of the home. They could stay for meals if they wished.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive to people's needs because people's care and support was not well planned. The care plans lacked any details about people's preferred routines and wishes. Without this detail it as difficult to see how staff delivered care in a way the person wished. The deputy manager explained they were introducing a new computer care plan system and this would give greater levels of detail and include more personalised information, but that uploading the plans onto the system was taking longer than they expected. They said they would look to have some additional administration hours the following week to get every person onto the electronic care plan system so staff had access to better and more personalised information. The paper care planning system had a number of pre-printed statements regarding level of care required, and the care staff would highlight the one which was required. In some cases more detail had been added to guide staff. By the second day of the inspection work had begun on improving the care plan information.

People were assessed before they moved into the home. However they had admitted some people whose needs were more complex that had not been identified through this process. The deputy manager felt that some people had not given the home the full information needed to ensure staff would be fully briefed on people's needs. At a safeguarding strategy meeting it was recommended to the registered manager than they consider using a GP summary sheet or similar when assessing needs of potential privately funded clients to ensure a clearer picture of the persons needs was obtained prior to them being admitted.

An activities organiser was employed to work between Primrose House and Donnington House for five days a week between the hours of 2 p.m. – 5 p.m. People from Primrose usually had to go over to the other home to attend activities and social events. Limited opportunities were available at Primrose House itself. The registered manager agreed that they needed to look at ways of increasing the amount of social activity that was arranged at the home. One relative said " I think [person'sname] ought to be more stimulated".

These issues identified above are a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said the admission process had gone really well. The registered manager had spoken to them on the phone and also other people involved in the care of their relative. They were very happy with the care provided and thought they responded very well to their relative's needs. They felt very involved in the care, and said staff phoned regularly to discuss what the best options' were.

One relative said that although there had been some initial 'teething problems' they were ''overall satisfied with the service. Staff really good.'' Another visitor said ''I can't fault the service, staff are wonderful. I can visit when I like and am offered a meal if I wish, which they don't charge me for. Building really lovely and care staff brilliant.''

Staff were able to describe what people's preferences were but agreed they were still getting to know people and would find it useful to have more personalised information about people's past histories. There were

separate sheets detailing who gave personal care for each person each day. These were up to date and completed. One relative said "[person's name] is always well presented. The only time [person'sname] are not spick and span is when they refused to get dressed. They have a shower almost every day". They added that if staff didn't know an answer to a question, they would always go immediately and find out. They had received all copies of information they needed from the deputy manager. Another relative said "They keep me up to date. They are very good with [person's name] personal care."

One newer member of staff described how they were asked to help get people to bed at a certain time. They said they were aware people were settled and did not show any indication they wished to retire to their rooms at that time. The member of staff did question this practice but was told they should follow instructions. We fed this back to the registered manager and deputy manager who said there was no set time for staff to help prepare people to get ready for bed.

There was a sheet advertising the activities happening in November and December. This included outside entertainers. There was a Christmas party on the 17 December at Donnington House and a Christingle service on 20 December. Within the home there were some games available. One person liked to play cards and another loved to knit and was happily engaged in this during the visit. One person liked to listen to classical music and a relative confirmed staff often put this on for them in their bedroom. A care worker said that day they had been doing some exercises with one person, and reminiscence cards with another. The registered manager told us they would be talking to all the staff about the importance of the keyworker role, whereby staff were allocated to individual people living at the home. Their role would be to work with the person and their families and to help to update care plans

After the inspection the registered manager told us that they would be discussing activities with the staff at a meeting on 22 December 2016. They had also devised a recording sheet for each person to evidence how their social and emotional needs had been met.

There was a formal complaints procedure. This was made available to people in the service user guide available for each person. We were aware of one formal complaint which the registered manager was completing at the time of the inspection. She had investigated this by looking at records and interviewing staff. She was in the process of typing this up and sending to the head office before it was sent to the complainant. Since the inspection the complaint response has been sent to the complainant. They were not satisfied with the response. We are awaiting to see a further response to this from the provider. There had been a number of concerns that had arisen from other relatives since the service opened and the deputy manager was going to check if these had also been logged as formal complaints. They felt that these needed investigating fully , so that they could formally apologise to relatives and learn from any lessons if required. They both volunteered that they had admitted a number of people with complex needs too quickly and this had led to the standard of care not being delivered as it should. They both acknowledged this and "held their hands up". Relatives we spoke to at the home knew how to make a complaint and were sure these would be dealt with. They had no need to make a complaint and knew they could speak to any of the staff at any time if they had a concern.

Requires Improvement

# Is the service well-led?

## Our findings

Some aspects of this service were not well led.

Primrose House opened in October 2016. The first person admitted to the home was on 20 October 2016. It is one of eight homes registered with Stonehaven Limited. It is situated next door to Donnington House. The registered manager is also the registered manager of Donnington House. There is also a deputy manager. At the time of the inspection, both the registered manager and deputy manager were mainly based at Donnington House. They did visit Primrose House numerous times during the day. However, in order to improve the overall management of the home the deputy manager was going to base herself in the office at Primrose House. They also had decided to look at the management structure within the home and increase the number of senior first care workers, as well as senior care workers. Senior first care workers had specific responsibilities within the home, such as keeping records up to date. There were no separate administration staff at the home, although one care worker undertook some office work. Staff felt that this had an impact on the day to day running of the home. Because the home was newly built, there were various issues that had arisen because of this. This meant that the registered manager and deputy had to spend time dealing with issues which took them away from supervising the care within the home. There had been no team building events for the staff before the home opened. This would have been helpful to discuss the culture, the ways of working, agree tasks for people.

Stonehaven Ltd have a number of directors and one of these had visited the home in the week before the inspection. They had met with staff and people living at the home. We spoke to one of the directors of the company and they explained a report had not yet been produced about the findings of this visit. A new post had been created within the company, where an area manager would carry out visits every six weeks and carry out a quality audit. The first one of these was booked for 2 January 2017. The service user guide for the service states "Primrose House will be visited by a director at least bi-monthly to ensure that all the standards outlined within this pack are adhered to. The person responsible for the day-to-day management of Primrose House is your Care Home Manager". At the time of the inspection; despite the concerns that had been raised about the quality of care, no detailed audits had taken place. We saw a copy of the audit system that is used for Donnington House. These included health and safety aspects, the environment, staffing, training, activities medicines, meals, health and welfare, complaints, care records. The registered manager and deputy manager said they had carried out some spot checks at the home, but had not recorded their findings.

These issues identified above are a breach in regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications had not been submitted to CQC as required by law. For example there had been at least one serious event that should have been submitted. The registered manager agreed to send any notifications retrospectively to CQC.

This is a breach of regulation 18 of the Care Quality Commission ( Registration) Regulations 2009

The registered manager was aware of the Duty of Candour requirements. This is when a registered person must act in an open and transparent way when a notifiable safety incident has occurred that has caused harm to a person. Currently one such complaint was being investigated and there were potentially other incidents that may need to be investigated by the registered persons.

The maintenance person had carried out a number of checks on a weekly basis such as fire safety. Fire alarms were tested weekly, and all fire escapes checked for obstruction. Window restrictors were checked monthly, hot water weekly. They were going to add bed rails and risk of wardrobes falling to the check list. Because the maintenance person was now responsible for two homes, it was hoped a part time person could be employed to help. Fire training had been completed and fire drills occurred once a week.

There had been a staff meeting on 5 December 2016. The deputy manager was arranging another meeting, as they needed to discuss lessons learned from all the concerns raised. "We need to look at how to get this right". There had been a residents and relatives meeting on 23 November 2016. People had been able to express their concerns. These ranged from laundry problems and people not having their faces wiped after meals. It was also an opportunity for updates from the home; such as the date for the Christmas party. There were handovers twice a day which staff found very useful. Also there were communications books on each floor which staff read to ensure they were updated about anything that had changed. This information was also kept in the care plans or notes. Staff were very complimentary about the registered manager and deputy manager. They felt they provided good support and could always go to them for advice and support. One said "The  managers are brilliant".

The registered manager and deputy manager have kept CQC updated with actions they have taken following the inspection.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Notifications of serious incidents had not been submitted to CQC |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>There were not suitable arrangements to ensure that care was planned and delivered to meet individual needs. People and their families had not been involved in developing care plans . |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>There were not suitable arrangements to ensure that people's legal rights were met at all time. Records were not in line with the legal requirements |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There were not suitable arrangements to ensure that people were protected from risk. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

There were ineffective quality assurance processes in place. Despite concerns being raised about the service there had been no audits undertaken to monitor and improve the service.