Abbey Healthcare (Huntingdon) Ltd

Primrose Hill Care Home

Inspection report

Thames Road
Huntingdon
Cambridgeshire
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Tel: 01480450099

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Primrose Hill Care Home is registered to provide accommodation and care, including nursing care, for up to 60 people, some of whom live with dementia. There are three dedicated floors where people live: the ground floor is called Heron Way; the second floor is called Kingfisher Walk and the third floor is called The Mallards. At the time of our visit 60 people were living at the home.

This comprehensive inspection took place on 9 January 2017 and was unannounced.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the CQC to manage the home. 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 Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was acting in accordance with the requirements of the MCA including the DoLS.

People told us they felt safe. Risk assessments were in place which gave staff the information they needed to minimise risks to people. Staff had an understanding of how to protect people from harm and knew what action they were to take if they had any concerns.

Staffing levels ensured that people received the support to meet their needs. There was an increase in the number of house-keeping staff to improve the hygiene and cleanliness of the sluice areas of the home. New staff were being recruited to fill vacancies. The recruitment practices protected people from being cared for by staff that were unsuitable to work at the home. Staff received the training and support they required to carry out their role.

Staff were kind and caring to people who they looked after. However, staff needed to take advantage of opportunities presented to them to improve the quality of their engagement with people. That said, they knew people well and were aware of their preferences, likes and dislikes. People's privacy, independence and dignity were upheld.

People were supported to take their medicines as prescribed. Records showed that medicines were administered as prescribed. People were helped to keep well because people were had access to healthcare services when needed. People's nutritional health was maintained: they had enough to eat and drink and nutritional supplements were provided for those people who were at risk of undernourishment.

Pre-admission assessments were carried out with the involvement of people and people who were important to them. People were actively consulted about their day-to-day care. However, there was a lack of

evidence that there was a more formal system in place to review people's care with their involvement. Activities were provided in communal areas and trips out were organised for those people who wanted to take part. However, there were times when there was a reliance on music or television to engage people in a more meaningful way. Work was in progress to improve the quality of people's recreational activities to maintain and promote their sense of well-being.

There was a complaints procedure in place and people felt confident to raise any concerns either with the staff or the manager if they needed to.

People knew who the registered manager was and they were provided with opportunities to make suggestions about how they wanted the home to run. The registered manager ensured that the staff team were supported and had the right amount of information to do their job. In addition, there were opportunities for staff to provide feedback about any improvements that could be made, although they were unable to give examples of these. Audits were carried out with increased supervision of staff to ensure that the safety and quality of people's care was maintained.

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

Staff were aware of the procedures to follow if they suspected someone might have been harmed.

Risks to people had been assessed and managed to keep people safe as reasonably as possible.

People received their medication as prescribed.

Is the service effective?

Good

People's rights were protected as the provider was acting in accordance with the Mental Capacity Act 2005.

Staff were supported and trained to provide people with individualised care.

People had access to a range of healthcare services to support them with maintaining their health and wellbeing.

Is the service caring?

Good

The service was caring.

The care provided was based on people's individual needs and choices.

Members of staff were kind and caring.

People's rights to privacy, independence and dignity were valued.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's dementia care, health and social care needs were not always met.

People were not actively involved in the reviews of their planned

care.

There was a system in place to receive and manage people's suggestions or complaints.

Is the service well-led?

Good

The service was well-led.

Staff were enabled to discuss any concerns they had with the management team and were confident to question any colleagues' practice if they needed to.

The provider operated an open culture and welcomed ideas for improvement.

Audits and actions plans ensured that the quality of the service provided was being constantly reviewed and acted upon.

Primrose Hill Care Home

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 9 January 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection we received information from local authority monitoring officers; an environmental health officer and a member of the local police force. This was to help with the planning of our inspection.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

During the inspection we spoke with the office manager; the registered manager; the regional manager; the business development manager and a unit manager. We also spoke with three registered nurses; three members of care staff; one of the three activities co-ordinators; the cook; one kitchen assistant; one member of the house-keeping [domestic] staff and a visiting NHS continuing health care professional. Furthermore, we also spoke with five people and two people's relatives.

We observed how people were being looked after. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care records and medicines administration records. We also looked at records in relation to the management of staff and management of the home, including audits and minutes of meetings.

Good

Is the service safe?

Our findings

People told us that they felt safe because of a number of reasons. One person said that they felt safer than when they lived at home, alone. They said, "I do feel safe because I know that there are people [staff] around." Other people said that the staff were kind and that this led them to feeling safe. One relative told us that their family member was safer than when they lived at home. They said, "I definitely do feel [family member] is in the right place now."

People were kept safe from the risk of harm because staff were training and knowledgeable about protecting people from harm. They were aware of the types of harm people might experience and the signs and symptoms of these. The activities co-ordinator said, "They [person] could get upset. Withdraw or show anger. [There could be] bruising." Other staff gave similar responses with all staff being aware of their roles and responsibilities in reporting such untoward incidents. This included reporting internally to the provider or to external agencies, such as the local authority, if there was a need to do so.

Required recruitment safety checks had been carried out before staff were allowed to look after people. Members of staff described their experiences of when they applied to work at the home. The office manager said, "I had to have a DBS [Disclosure and Barring Service police check]. I had to have two references; one from my present employer and one from another previous employer. I had three interviews [with different managers]. I had an application form and a health declaration form." The cook also told us that they had to have the required checks in place, which, too, included their employment history. Staff recruitment files demonstrated that staff had the required checks carried out before they were deemed suitable to work at the home. The provider had a disciplinary procedure in place. This was used in the event of staff failing to meet the standards expected of their role in providing people with safe care.

People's risks were assessed and measures were in place to manage the risks. These included, for example, risks associated with moving and handling and risks of developing pressure ulcers. Measures taken to mitigate such risks included the use of appropriate moving and handling equipment with the support of two members of care/nursing staff. Repositioning records demonstrated that people were helped to alleviate harmful pressure to their skin. In addition, people were provided with pressure-relieving mattress and cushions when in bed and when sitting in a chair.

We found that there was a sufficient number of staff to look after people. We saw that staff were patient when helping people in an unhurried way. In addition, people's call bells were responded to within less than five minutes. People were helped to take their prescribed medicines at a pace that suited them. We also saw that people were helped to eat and drink by individual members of care/nursing staff and this was carried out in an unhurried way. One relative said, "There is always people [staff] about." The business development manager told us that they had carried out an unannounced visit during the early evening hours of 6 January 2017. They said that they had chosen the day and time as this was one of the busier times in the home. They told us that they found that people's individual needs were met because there was enough staff to do so. To fill staff vacancies there was active recruitment of new staff. Newly employed staff were working their first day when we visited: this included, for instance, one registered nurse and the cook.

People's needs were assessed and the staffing numbers were matched in line with the level of people's assessed needs. People and members of staff, including housekeeping staff, said that there was usually enough staff. One person described how staff worked on different units and this was confirmed by one of the registered nurses. The registered nurse explained that staff would work different areas of the home, depending on the needs of people. One member of care staff said, "Sometimes the numbers of staff are short as staff ring in sick. There is a bank member of staff member on today." One member of house-keeping staff said - and this was confirmed by the registered manager - that an extra member of house-keeping staff was working to improve the cleanliness and hygiene of the sluice areas. (A sluice is where waste, including clinical waste, is managed.)

The office manager said that, in the event of unplanned sickness, other staff were asked if they were able to work extra hours. The activities co-ordinator explained that they had a dual-role, which had enabled them to serve people with their breakfasts, which we saw them doing. They added that every day there was an activities co-ordinator working at the home. The registered manager told us that they had reviewed the number of activities co-ordinators and was aiming to increase the number of these from three to five. This was to improve the quality and frequency of people's recreational activities.

We found that people were protected from unsafe management of medicines. Medication records showed that people were given their medicines as prescribed by qualified registered nurses. Registered nurses had undertaken refresher training to ensure that they remained safe in this area of their professional practice. Medicines were kept secure and the ways that these were stored ensured that the quality of the medicines was maintained.

We saw that people were given their prescribed medicines in a way that they were able to swallow and at a pace that was comfortable for them. This was because nursing staff were patient with individual people when assisting them to take their prescribed medicines. One person told us that they had their prescribed medicines every day and also told us how their pain was managed by the application of 'patches'. They said that the 'patches' were applied in alternative areas, "One on my left side and the next one on my right." Care records showed that people had their 'patches' applied on alternate areas of their skin. This safe practice reduced the risk of soreness of the skin.

'As required' medicines were given in line with prescribed protocols. Although care/ nursing staff had access to care plan guidance in how to manage people's unsettled behaviours, this information was not directly available in the 'as required' protocols. The regional and registered managers assured us that this detail would be added to the 'as required' protocols; this was to ensure that people were given 'as required' sedation only as a last resort. We found that such sedation was used when other strategies had failed to ease the person's sense of being unsettled.

Personal emergency evacuation plans were in place for each person. This meant that staff had the information they needed if people needed to be moved to a place of safety in an emergency.

Good

Is the service effective?

Our findings

We checked to find out if people were being looked after in a way that protected their rights. We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 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 registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the provider 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 provider had submitted DoLS applications to the appropriate authorities for their review. When any of these had been authorised the provider was following the conditions of the authorised DoLS. This included making sure the person was kept safe in the premises of the home and to be given, legally, 'covert' [disguised/hidden] use of prescribed medicines. Mental capacity assessments were in place and when people lacked mental capacity, 'best interest' decisions were made by health care professionals. This was in conjunction, with people's representatives so that people would take their medicines disguised in food or drink, based upon a justified 'best interest' decision as agreed by all parties involved in the process.

Staff were trained and had some knowledge about the application of the MCA, and DoLS and were aware of the significance of 'best interests' decisions. One member of care staff said, "Deprivation of Liberty orders are if someone [person] does not have [mental] capacity to make decisions and we can make decisions for them. This has got to be in their 'best interest'."

Members of staff said that they had the training to do their job. This included induction training which involved completion of the nationally recognised Care Certificate. Staff training records showed that staff had attended a range of training which included, for example, infection control; food safety; moving and handling and dementia awareness. Staff were able to demonstrate their knowledge to show how effective their training was. This included, for instance, the wearing of disposable gloves and aprons when providing people with personal care and serving people with their lunch; the use of moving and handling equipment with two staff members at all times. Following on from this staff had an understanding of how dementia often affects people's interpretation of their world. One member of care staff said how they would not 'correct' a person, who was living with dementia, if they believed something that was not factual. They said, "[You] engage in their conversation but you don't tell them that their time frame is wrong." They gave an example of how they gave one worried person reassurance, who believed that their parents, who were waiting for them, were still alive. They staff member explained this strategy helped the person to become settled, less anxious and reassured.

Supervision arrangements were in place to ensure that staff were supported and reminded about their responsibilities of their individual roles. The registered manager told us that staff who were failing to maintain standards of their work would have increased supervision. Members of staff from all departments said that they felt supported by the management team and by their colleagues. One member of care staff said, "I love it here…It's a good atmosphere. It's a good team." One member of house-keeping staff said that they were "encouraged" to interact with people. They said that they found this helped them to feel a member of the whole staff team.

People's nutritional needs and choices were met. People said that they liked the food and were enjoying a choice of toad-in-the hole or a beef dish with vegetables. One relative described how staff "encouraged" their family member to eat as much as possible. They added that, because their family member was not eating sufficient amounts, they were given nutritional supplements. We saw people, who were at risk of undernourishment, taking nutritional supplements in the form of chocolate mousses. People's weights were recorded and the frequency of these depended on the level of assessed risk. Records demonstrated that people's weights remained stable due to having adequate nutritional intake.

People were offered a choice of hot and cold drinks and written menu choices were available on white boards in the main dining areas of the home. One person said that they were able to read what this information was as they were unable to recall what they had ordered the day before. The kitchen assistant said that if people did not want what they had choices, "We always do [cook] spare [food] and if they [people] change their mind, they are always welcome to change their mind."

People's health was maintained. The care records showed that when people needed to see a doctor or other healthcare professional this was always organised for them in a timely manner. One person told us that that they had been seen by a GP to be treated for an eye condition and to have their pain managed by means of prescribed analgesia. People with diabetes had their blood sugars monitored by the home's employed registered nurses. However, due to the lack of recorded information, it was not clear if the results of people's blood sugar monitoring were within a 'healthy' range. We brought this deficiency of recording to the attention of the regional and registered managers who agreed that they would take action to improve this area of recording.

Good

Is the service caring?

Our findings

People told us that they were well-looked after because staff were kind and caring and we found some good examples of this. One relative said, "Staff here seem to be engaged [with family member] and will leave me alone when I am visiting [family member]. I think this is to respect our privacy." We saw members of staff from different departments, including the registered manager; engage with people in an attentive way. This included during lunch time and during recreational activities. Another example was when one of the registered nurses was helping a person with their prescribed eye drops. We heard them say, "When you are ready. One more time. Is that alright?" However, we found that there were occasions when staff missed opportunities to engage with people in a meaningful and acknowledging way, as they walked by.

Members of staff were able to demonstrate their understanding of the principles of good care. One member of care staff said, "[The] quality of the care here is compassionate. Everyone is respectful." The activities co-ordinator told us, "[The care] is about people's rights to choice. We ask them what they would like to wear. What they want to eat. It [care] is about their [people's] rights to privacy, independence and respect." We saw that when staff helped people with eating and drinking, this was carried out in a respectful way. We noted that when staff were speaking to people or helping them with their food and drink, this was often done at eye-level, rather than standing over them.

We saw staff encouraged people to remain as independent as possible. This included independence with eating and drinking and personal care. When this was not possible, staff helped people with these areas of their care.

We saw that staff offered people choices of what they wanted to do and what they wanted to eat and drink. People's choices of when they wanted to get up and go to bed was valued and carried out as best as possible. One person said that on one occasion they were not helped to bed at a time when they usually liked to. However, they said that this was not a usual occurrence.

The premises maximised people's privacy. All bedrooms were for single occupancy only and communal bathing and toilet facilities had overriding locks on the doors. When people were receiving personal care in their rooms, signs were used to warn people on the outside of this fact and not to enter. When staff were to enter people's rooms, they knocked, although did not always wait for the person's permission, before entering.

We found that the management of people's urinary catheter bags reduced how people's privacy was valued. We saw two people, who were in bed, had their catheter bags by their side but were in sight of public view. We brought this to the attention to the regional and registered managers.

When people had needed independent help to make some important decisions the registered manager had advised us that there were advocates available to support them. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

We saw that most people, who were living with dementia, had their individual needs met with some exceptions. We saw that for one person, who was unsettled and knocked over their drinking glass and side table, had little in the way of attention from members of care staff. The person became settled only after one member of care staff sat with the person and engaged with them in a full, caring and meaningful way. This strategy responded to the person's emotional needs as we saw that they then became settled and happier.

Another example was when people, who were living with dementia, had chosen what they wanted to eat the day before or the following morning, rather than at the time their meal was due to be served. This method failed to consider people's difficulties with remembering or failed to use people's strengths of smelling and seeing. This sensory stimulation enables people, who are living with dementia, to choose better from a visual/sensory presentation of the menu options. Furthermore, the timing of this would, possibly, enable people to have immediate recall of the information presented to them and make their choice from thereafter.

We found a toilet area, for the use of people living with dementia, was temporarily used for storage of large boxes of continence aids. This prevented people entering the room to use the facilities. We showed the business development manager this blocked off area who said, "Whoa! On a unit where people usually find it difficult to find a loo." Staff took remedial action to clear this area so that people were able to find where the toilet was, as they had been used to before.

We saw that recreational activities were provided for people in communal areas and within their own rooms. This included the use of music instruments; manicures for women and visits from external entertainers. One person showed their happiness of how they were looking forward to joining in with the forthcoming entertainment by a visiting musician/singer. Another person said, however, that they did not have enough to do and often got "bored." We often saw people were engaged in watching television, listening to music or looking around the room or were asleep. We found insufficient evidence that more appropriate recreational activities were provided, especially for those people living with dementia.

People told us that they were satisfied with how they were looked after. One person said that they believed staff knew them as a person, what they liked to have to eat and what help that they needed. They told us that their needs were met, which included their mobility needs. They described how they were able to walk short distances, which was an improvement from when they first admitted to the home. One relative said, "My impression is that the care [family member] has received is that it is good." We saw people's continence and nutritional needs were met. For example, we saw people were helped to use the toilet facilities and to eat and drink. We also saw that some people preferred to drink out of a mug or a beaker, depending on their individual needs and choice.

People were able to receive their guest when they wanted to. One relative also said that they were able to visit any time they wanted to. We saw people receiving their guests in private or in the communal lounges. People were also enabled to make friends with each other. We saw people talking with each other and two

people comfortably holding each other's hands.

Before people were admitted their needs were assessed to ensure that the home was a suitable place for them to move into. One person said that the registered manager had visited them and were asked, "What I wanted and what I needed." One relative told us that they, and later their family member, had visited the home before the registered manager carried out the pre-admission assessment. Another relative said, "I had to fill out a questionnaire about [family member's] likes and dislikes. What food [family member] likes to eat."

Subsequent to the pre-admission assessments people's care plans were developed. These were detailed and contained information for staff to enable them to meet people's needs. They were written in a positive manner and included information about the individual and what they were able to do for themselves. The visiting NHS continuing health care professional said, "The risk assessments are up-to-date. The care records tell me what I need to know. Staff have been able to answer my questions and it correlates with the care plan."

People and their relatives were included in day-to-day discussions about people's planned care. However, there was insufficient evidence to tell us that there was a system in place which included people, and people who mattered to them, in formalising the review process. We were therefore not fully confident that the provider continually operated an inclusive and overall reviewing process in relation to people's planned care.

The provider had a complaints procedure in place which staff and people and relatives were aware of. Staff knew what to do in the event of being made first aware of a concern or complaint. This included telling the person what action they would take in reporting their issues to the relevant managers. The record of complaints demonstrated that issues were responded to and resolved as best as possible to the satisfaction of the complainant. Once person told us that, after they had raised their concerns about part of their care, they were now assisted to bed at the time that they wanted.

Good

Is the service well-led?

Our findings

A registered manager was in post when we visited. People and relatives said that they knew who the registered manager was. Staff had positive comments to make about the registered manager's leadership style. One member of staff described them to be "often approachable." They and other staff members told us that the registered manager was "very caring" and helped the staff with looking after people and, when needed, helped with kitchen duties.

People and their relatives were provided with opportunities to be involved in the running of the service. The regional and registered managers said, however, that there had been a lack of interest from all parties who had been invited to attend the meetings. They advised us that they would consider ways of attracting an increased interest for such meetings to be better attended. The registered manager told us that they operated an 'open-door' policy which staff, people and visitors were able to use to make suggestions or comments about the standard of the service provided at the home.

Members of staff were also provided with opportunities to make suggestions and comments during staff meetings although they were not able to provide examples of when they had done this. However, they said that the staff meetings were "informative" and "instructive" to remind them of their roles and responsibilities in proving people with safe, quality of care. Minutes of the staff meetings showed that staff were reminded to, for instance, to follow correct infection control procedures. In addition to staff meetings, staff were provided with opportunities to share their views with the provider by means of a survey. The regional manager told us that this was still on-going as not all staff had completed their survey.

There were other quality assurances systems in place to ensure that the home was a safe place to live, work or visit. The registered manager was responsible in reporting to their line manager each week of events that had taken place in the home. The reports showed that information, for example, about staff training planned and attended; complaints and accidents and incidents was recorded and shared with the regional manager. The regional manager explained that they reviewed the registered manager's report and developed an action plan, with timescales, for the registered manager to complete.

An action plan was in progress and actions were being signed off when these had been completed. However, we found two areas where improvements had not been maintained. One of these was in relation to the inadequate storage of fresh vegetables. We found the condition of these had deteriorated and the cook took immediate action to have these thrown away. Another area was the return of the practice of staff storing moving and handling equipment and continence aids in bathrooms and toilets. The action plans had noted that these had been previously cleared by the latest of 6 January 2017. We made the business development manager and regional and registered managers aware of these slippages from their quality improvement actions. They advised us that they would take remedial action to remind staff what was expected of them.

Another quality assurance system used was in relation to an analysis of accidents and incidents. The regional manager described the actions that were taken based on an increased number of recorded

incidents of people falling during two identified summer months of 2016. There was a review of a number of areas, which included that of people's food and drink charts and staffing numbers. The regional manager advised us that there was no remedial action required other than introducing a protocol for staff to follow after any person had fallen and required medical assistance.

The provider aimed to operate and open and transparent culture of the management of the home. On clear display was the last CQC rating of the home. Furthermore, required notifications had been submitted with the exception of one. This was in relation to one person who was subject to an authorised DoL during August 2016. The registered manager said that they were not aware of this requirement but took subsequent action to rectify this omission. In addition, the registered manager had subscribed to a training programme to increase their knowledge about when CQC was to be notified in relation to important events that affected people.

Another example of how the provider operated an open and transparent culture was by means of community links. One person told us that religious services were held in the home and that they believed people had attended carol singing in and out of the home.

Staff told us that they were aware of the whistle blowing policy and procedure and when this was to be used. The activities co-ordinator said that they would use this if they found a colleague was not looking after people as they should. They added, "One hundred percent I would blow the whistle." None of the staff had reservations in using the whistle blowing procedure. This showed that the provider had a system in place to encourage staff to speak up to safeguard people and without fear of reprisal.