Rosehill (UK) Limited

Rose Hill Nursing Home

Inspection report

9 Rose Hill
Dorking
Surrey
RH4 2EG
Tel: 01306882622
Website: www.rosehill.com

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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

Overall summary

Rose Hill Nursing Home is registered to provide nursing care and accommodation for up to 35 older people some of whom are living with dementia. There were 27 people living at the service during our inspection. The home is located close to Dorking town and within easy access to local amenities and facilities. Bedroom accommodation is arranged over two floors. A passenger lift provides access to the first floor. Bedrooms are single occupancy and some have en suite facilities. There is a large garden to the side and rear of the service and a small car park is available at the front.

This inspection took place on 26 November 2015 and was unannounced.

The home was run by a registered manager, who was present on the day of the inspection visit. '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.

Summary of findings

Assessments were in place for identified risks. Risks were well managed and reviewed and updated on a regular basis. These had been reflected in people's care plans.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. Staff said they would report any concerns to the registered manager. The staff we spoke to knew the types of different abuse and where to find contact numbers for the local safeguarding team if they needed to raise concerns.

There were sufficient numbers of staff deployed who were appropriately trained to meet the needs of the people who lived at the service. Staff had the appropriate and up to date skills and guidance in relation to their role.

Procedures were in place for medicine administration. People received their medicine as prescribed. All medicines were administered and disposed of in a safe way.

Staff were aware of the home's contingency plan, if events occurred that stopped the service running. They explained actions that they would take in any event to keep people safe. The premises provided were safe to use for their intended purpose.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been submitted where restrictions were imposed to keep people safe. People's best interests had been considered when they needed support to make decisions.

People had access to a range of health care professionals, such as the GP, community psychiatric nurse, dentist and opticians.

People had enough to eat and drink and received support from staff where a need had been identified. One person said "We have a choice of meals and can always ask for something different." Specialist diets to meet medical, religious or cultural needs were provided. People had access to drinks and snacks at any time during the day and night.

People were treated with kindness, compassion and respect, and their privacy and dignity was respected at all times. People were encouraged and supported to be involved in their care. People's bedrooms had been decorated to a good standard and were personalised with their own possessions.

People had individual care plans. They were detailed and updated regularly. We saw staff had the most up to date and appropriate information to enable them to respond to people effectively.

The registered manager operated an open door policy and we saw several examples of this throughout the day when staff, relatives and people who used the service sought their support and advice. People were aware of the complaint procedures and told us they would know how to make a complaint.

The registered manager had maintained accurate, complete and detailed records in respect of people and records relating to the overall management of the service.

The service had systems in place to record and monitor the quality of the service provided. Accidents and incidents were recorded and acted upon.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Risks were assessed and managed well, and risk assessments provided clear information and guidance to staff.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

Medicines were managed safely, and people received their medicines in a timely way as prescribed.

Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Is the service effective?

Good

The service was effective.

Staff received regular training to ensure they had up to date skills and knowledge to undertake their roles and responsibilities. They also had regular one to one meetings with their manager.

Mental Capacity Assessments and best interest meetings were in place for people where they lacked capacity and DoLS authorisions had been applied for.

People were supported to eat and drink according to their choice and plan of care.

People's health care needs were being met.

Is the service caring?

Good

The service was caring.

People were well cared for and their privacy and dignity was maintained.

We observed staff were caring and kind and treated people kindly and with respect.

Staff were professional, patient and discreet when providing support to people.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

Care plans were well maintained.

There were activities provided for people who chose to participate.

Complaints were monitored and acted on in a timely manner.

Summary of findings

Is the service well-led?

Good

The service was well led.

The provider had system in place to monitor the quality of the service provided.

The registered manager had maintained accurate records relating to the overall management of the service.

Staff were supported by the registered manager.

There was open communication within the staff team and staff felt comfortable discussing any concerns about the service.

Rose Hill Nursing 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 26 November 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. Notifications are information about important events which the provider is required to send us by law. The provider sent us a provider information return (PIR) before the inspection. The PIR is a form that askes the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with nine people, six members of staff, the registered manager, five relatives, the chef and two health care professional.

We spent time observing care and support being provided. We read five people's care plans medicine administration records, recruitment files for staff, supervision records for staff, mental capacity assessments for people who used the service and other records which related to the management of the service such as training records and policies and procedures.

The last inspection of this service was 25 September 2013 where we found the regulations were being met and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe and did not have any concerns. One person said "I feel safe living here and I worry about nothing." Another person said "I came here not knowing what to expect, but I know I feel safe." A relative said "This is a safe place for my family member to be."

People were kept safe because staff understood their roles with regard to safeguarding people from abuse. We spoke to staff about keeping people safe and their understanding regarding safeguarding people. They had a good understanding of what constituted abuse and the correct procedures to follow should abuse be identified. For example, one member of staff was able to describe the different types of abuse and what the local authority safeguard protocols were. They said, "I would report anything to the registered manager or the nurse in charge." There was a safeguarding procedure in place and staff we spoke with were familiar with this procedure. This also provided staff with contact details of the local authority should they require this. All staff had undertaken training regarding safeguarding adults and this was updated annually.

The provider had undertaken appropriate recruitment checks to ensure staff were suitable to work in the service. Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information. We noted criminal record checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation including character references, job descriptions, proof of registration with the Nursing and Midwifery Council (NMC) and Home Office checks regarding eligibility for staff to work in the UK.

We looked at the staff duty rota for the previous four weeks. The rota revealed staffing levels were consistent across the time examined, with five to six care staff, one registered nurse plus the registered manager during the day and two care staff and one registered nurse at night. There was also kitchen, domestic and maintenance staff employed to support the provision of service. The provider used existing staff where possible to cover vacant shifts due to sickness or annual leave. The provider did use agency staff from time to time. We were told the provider always tried to employ the same agency staff to avoid disruption.

People told us there were always enough staff available to help them. We asked how safe staffing levels were established by the provider. The service used a formal tool to assess the changing needs of individuals and calculated staffing levels accordingly. Our examination of care plans confirmed this. We also looked at the electronic call bell register for a recent two week period. This provided a record of when people used their call bells and how long staff took to answer them. We noted that call bells were answered almost always within two minutes. People told us they never had to wait long for assistance. One person said "They are very good and always come immediately when I ring my bell." Another person said "Staff are very efficient and will come to help me when I use my bell."

Risks to individuals were appropriately managed. When risks had been identified risk assessments were in place to manage these risks. These were detailed and contained information for staff to follow around what the risks were to people and the measures needed to be taken to reduce the risk of harm and staff followed these guidelines. Some of the risk assessments we looked at included moving and handling, nutrition, skin care, personal care, communication needs, medication management, continence management or social activities. These were constantly updated either routinely or when needs changed to ensure people's needs were met.

People's medicines were managed safely. We asked how medicines were acquired, administered and disposed of. We examined the medicine administration records (MAR) charts. We also observed the dispensing of medicine and examined the provider's medicine management policy. We were told the provider conducted regular direct observation of staff administrating medicines. Our examination of documentation confirmed this.

The administration and management of medicine followed guidance from the Royal Pharmaceutical Society. Staff locked the medicine trolley when leaving it unattended and did not sign MAR charts until medicines had taken by the person. There were no gaps in the MAR charts. These charts contained relevant information about the administration of certain drugs, for example medicine used for heart disease and for pain management. Staff were knowledgeable about the medicines they were giving. The provider carried out regular audits of medicine

Good

Is the service safe?

management and also facilitated yearly audits from an external provider. Any issues identified as a result of these audits were addressed in order to maintain the safe and effective management of medicine.

All medicines were delivered and disposed of by an external provider. The management of this was safe and effective. Medicines were labelled with directions for use and contained both expiry date and opening date. Creams, dressings and lotions were labelled with the name of the person who used them and safely stored. Other medicines were safely stored in trollies. There was a dedicated lockable room for the storage of medicines. A fridge was provided for medicines that require to be refrigeration and was not used for any other purpose. Controlled medicine was managed, stored and recorded safely. We noted nobody in the service managed their own medicine and no person received their medicine covertly, that is, without their knowledge or permission.

The premises were safe for people who lived in the service. Radiators were covered to protect people from burns; people's bedrooms were personalised with ornaments and photographs. Fire equipment and emergency lighting were in place and fire escapes were clear of obstructions to help people get out of the house in an emergency. Windows had the appropriate and safe restrictors in place to prevent falls. People had PEEPs (personal emergency evacuation plans) in case of fire or emergency. This is a plan that is tailored to people's individual needs and gives detailed information to staff about supporting people's movements during an evacuation.

The registered manager told us the home had an emergency plan in place should events stop the running of the service. Staff confirmed to us what they would do in an emergency.

Good

Is the service effective?

Our findings

People were supported by a staff team with the skills and knowledge to meet their assessed needs. A staff member told us they had attended several training days and felt they had the knowledge to undertake their roles. One member of staff said "The manager makes sure we know how to do things." People said they were well cared for and staff understood them and their needs. One person said "I do not like being rushed when I get up from my chair and the staff know exactly how to move me."

There was an effective induction and programme of ongoing training for staff. We looked at staff files to ascertain how new staff were inducted to employment at the service. They showed this process was structured around allowing staff to familiarise themselves with the service policies, protocols and working practices. We noted the provider had introduced the Skills for Care Certificate training as part of staff introduction. This provided staff with an identified set of standards that health and social care workers adhered to in their daily working life.

We examined the 2015 training matrix. We noted all staff were able to access training in subjects relevant to the care needs of the people they were supporting. This included infection control, health and safety, moving and handling people, food hygiene, and caring for people with dementia.

Staff received a good level of support to enable them to carry out their roles. The provider offered training to staff which had been identified during supervision. We looked at staff supervision and appraisal records. We noted that supervision sessions and yearly appraisals were undertaken or planned in line with the provider's policy. This was offered in both group and one to one settings. Staff confirmed they had regular formal supervision and said they could talk about issues in the service or personal to them. They also said objectives and goals were discussed and set for the coming year.

The Mental Capacity Act 2008 (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 interest and as least restrictive as possible.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes is are called the Deprivation of Liberty Safeguards (DoLS). People who required them had DoLS authorisations in place that had been authorised by the local authority.

Staff had undertaken training regarding the Mental Capacity Act 2005. Staff said "I would never undertake a procedure before asking the person first." We noted written consent was sought and obtained from people or their representative with regard to the use of bed rails, photography for identification purposes and sharing of information with other agencies. We saw some good care practice throughout our visit when staff promoted choice regarding personal care, menu choice and activity participation. For example, one person's care plan stated that the person's mental capacity fluctuated, which meant their ability to make decisions for themselves varied from day to day. We noted this person's mental capacity was regularly assessed to monitor this. The mental capacity care plan also contained steps staff should take to maximise the person's ability to make decisions for themselves whenever possible. This is in line with the Mental Capacity Act (2005) which states that all individuals are assumed to have capacity unless otherwise proven.

One person said "The health care I get is very good and I have nothing to complain about." A relative told us the service always kept them informed regarding any changes. They said when my family member was ill I could ring at any time and staff were able to update me and knew what they were doing."

People were supported to keep healthy, and had access to appropriate health care professionals when needed. People told us they were satisfied with the support they received from health care professionals. They said they were able to see their doctor when required.

Care records showed people's health care needs were monitored and action taken to ensure these were addressed by appropriate health care professionals. People were registered with a local GP who visited the service

Good

Is the service effective?

weekly or more frequently if required. One person said "I am very pleased with the support I get from my doctor." People had access to dental care, a chiropodist, and an optician regularly. Specialist input from a tissue viability nurse (TVN) community psychiatric nurses (CPN) and a continence advisor were also in place. We noted advice and guidance given by these professionals was followed. Comments from both health care professionals we spoke with were satisfied with the care provide. Appointments with consultants or specialists were made by a referral from the GP. We saw records were kept in care plans of visits from health care professionals. This included any changes to medicine or new treatments prescribed.

People had enough to eat and drink. People told us they enjoyed their food and there was always something they liked to eat on the menu. Relatives told us the food always looked appetising and wholesome. People's nutritional needs had been assessed using a malnutrition universal screening tool (MUST). Menus were displayed on the notice board in the lounge and on the dining tables. There was at least two choices of main course. We observed lunch and saw people enjoyed their food in a relaxed and unhurried atmosphere. Tables were nicely laid with linen table cloths and condiments. A selection of fruit juices and water was also offered to people. There was also a choice of deserts available. We saw staff were available to support people who required assistance to eat their meal. Some people choose to eat in their rooms and staff were also available to support people who wished to eat in their rooms.

People's weight was recorded and any weight loss or gain was discussed and appropriate action taken if necessary. We spoke with the chef who had a good understanding of people's dietary needs and regularly met with people to listen to their suggestions and made changes when required to do so. Special dietary needs and preferences were catered for. This included people who required a diabetic diet, a soft or pureed diet and a vegetarian or cultural choice.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "I like it here and staff treat me very well." Another person told us "I want for nothing and staff go out of their way to care for me." A relative said "Staff are really caring and are always welcoming, and the good thing is they don't change too often."

Staff were very caring and attentive to people's needs. There was excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. When staff had a moment they sat beside people and took an interest in what they were saying. For example one person had lived on a farm and was telling a story about some of the animals they looked after. It was evident throughout our observations that staff had enough skills and experience to manage situations as they arose and that meant that the care given was of a consistently good standard.

Staff were knowledgeable about people and their past histories. Care plans contained both life histories and social assessments. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships, for example people's previous occupations and hobbies.

People were involved in the planning of their care. All care plans and risk assessments were reviewed monthly and signed by staff. People and their representatives had regular formal involvement in care planning and risk assessment. People's views were sought on care plans and consequently there were opportunities to alter the care plans if the person did not feel they reflected their care needs accurately.

People's privacy and dignity was maintained and people received personal care in the privacy of their bedrooms or in bathrooms provided with lockable doors. If people wished to have gender specific staff to undertake personal care this could be accommodated in order to promote dignity. We observed staff calling people by their preferred names and knocking on bedroom doors before entering. We noted each persons care plan contained a section which specifically addressed issues of dignity and privacy

The home had also a nominated 'dignity champion'. The roles entailed educating and raising awareness of relevant issues amongst staff and promoting good practice. We saw staff were respectful and spoke to people kindly and in a dignified was throughout our visit.

Staff ensured when people used hearing aids that these were in good repair and had batteries that worked. Staff also ensured that people who wore glasses had these available and were clean. A relative said they were reassured to see their family member wearing their hearing aid when they visited and said "It goes to show staff care about people's individual needs."

People looked well cared for. Their clothing was clean and fresh and colour coordinated, and people wore appropriate footwear which meant staff had taken the time and effort to support people with their personal care. Their hair was nicely kept and people told us the hairdresser visited every week and they were able to make appointments to have their hair "done." It's important to look nice."

People were encouraged and supported to make choices regarding their daily living routines. People could have their breakfast in bed or in their room according to how they felt on the day. People had the choice how they wanted their personal care undertaken. For example if they liked a bath or a shower and if they preferred this in the morning or the evening. They also chose where to spend their time and what activities they participated in.

One person said "I am very comfortable here and look at the lovely view I have." A relative said "The rooms are very individual and we are encouraged to bring personal items to help make it homely." Bedrooms were pleasantly decorated and people had the opportunity to bring personal possessions and items of furniture with them into the home. People invited us to view their rooms.

Relatives told us they could visit their family member at any time and always found them well cared for. They could visit their relative in the privacy of their room or there were private areas throughout the home that people were able to use. .

End of life arrangements had been discussed with people, their relatives and the multidisciplinary team. We saw that advanced care plans were in place where appropriate and these were regularly updated with input from other health care professionals.

Good

Is the service responsive?

Our findings

People told us they had been consulted and included in the planning of their care. People had needs assessments undertaken before they were admitted to the service in order to ensure the service had the resources and expertise to meet their needs. People told us the registered manager visited them in hospital or at home to undertake the assessment.

People's choices and preferences were documented and those needs were seen to be met. Care plans were legible, person centred and up to date. They contained information about people's care needs, for example in the management of risk associated with environmental hazards and medicine management. The care plans also contained detailed information about personal histories and likes and dislikes. People's choices and preferences were also documented. The daily records showed that these were taken into account when people received care, for example their choice of food and drink. Care planning and individual risk assessments were reviewed monthly and audited yearly to ensure they contained detailed and relevant information.

People had access to activities that met their hobbies and interests. There was an activity plan in place which was overseen by an activities coordinator. They were supported by staff to ensure people were able to take part in activities of their choice which includes art and craft, music and exercise, board games, sing along and seasonal events like making Christmas decorations and cards. We spoke with people who were taking part in an art and craft session making Christmas cards. They all said they were enjoying this. One to one activities were also organised for people who chose to stay in their rooms to prevent them from becoming socially isolated. Relatives told us they were included in organised events and were looking forward to the Christmas party which was a big social event.

People's cultural and spiritual needs were observed. Regular visits from local clergy were arranged and people were able to have Holy Communion when they wished.

People were supported by staff that listened to and responded to complaints. One person said "I have not had to make a complaint and if I had any issues I would talk to the manager who would solve them immediately." People were provided with a complaints procedure when they were admitted to the home and there was a copy of this displayed in the reception area. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies such as the Care Quality Commission and the local authority. There had been two formal complaints made this year. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent further issues.

Relatives were reassured that if they had to make a complaint that their concerns would be acted upon. One relative said "I have had a few niggles like a lost nightdress but these always get resolved. I have never made a formal complaint."

Good

Is the service well-led?

Our findings

People told us they were satisfied with the management structure and support in place. They told us they felt listened to and the management team were capable and efficient. One person said "They come and talk with me every day and are genuinely interested in how I am feeling."

Relatives told us they could talk to the manager at any time. One relative said "The manager is always ready to listen if I have any worries about my family member they are in capable hands."

The service was being managed by an experienced registered manager and had the support of a deputy manager who also clinical responsibilities. We observed they had good lines of accountability with defined roles and responsibilities.

Staff felt supported by the management arrangements in place. Some staff had worked in the home for several years and told us they enjoyed working there. One staff member said "I have regular training and enjoy what I do." Another staff member said "I really enjoy working here fee part of a team." During conversation with staff they showed an understanding of the principles and values of the home. For example providing compassionate and safe care for people living there.

The provider had systems in place to monitor the quality of the service. The manager undertook internal audits including reviews of care plans, risk assessments, audits of medicines, infection control and training audits to further enhance the care provided. Housekeeping audits and catering audits were also undertaken and people's feedback welcomed in order to improve services.

Health and safety audits were undertaken to ensure the safety and welfare of people who used the service, people who visited the service and to promote a safe working environment. We saw records relating to health and safety for example maintenance checks, utility certificates, fire safety, and equipment were maintained to a high standard by the maintenance department.

We viewed the overall business plan for the service. This addressed areas for improvement such as an ongoing programme of refurbishment and decorating.

Staff were encouraged and included in the running of the home. For example taking a lead role in medicine administration or infection control. Staff told us they had staff meetings and were able to discuss any concerns regarding matters in the home or issues they had openly. We saw the manager operated on open door policy and we saw staff members were able to approach the registered manager during our inspection and were supported in open and inclusive way. A member of staff said "The manager is always available and will always assist if required. She will give us encouragement where it is due"

People and relatives were included in how the service was managed. Residents and relatives meetings took place and minutes of these meetings were kept in the service for information. Relatives mainly spoke on behalf of people who use the service to communicate their views. People were encouraged to make suggestions and the provider took these on board. For example changing the menus in accordance with people's preferences and providing additional activities like trips to the local theatre.

People and their families or representatives were asked for their views about the care and treatment given. These were sought via completed satisfaction questionnaires on a yearly basis. We looked at the latest results of May 2005 survey, which sought views of seven relatives. There were high satisfaction levels amongst people and their families particularly in the areas of quality of care, staff attitude, catering and management. Comments included "This is a lovely home and the staff are very caring." Another comment was "A home from home with a nice atmosphere."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed CQC of significant events that happened in the service in a timely way. This meant we could check that appropriate action had been taken.