Rosevilla Residential Home Limited

Rosevilla Residential Home

Inspection report

Penkford Lane
Collins Green
Warrington
Cheshire
WA5 4EE

Tel: 01925228637

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection of Rosevilla Residential Home on 23 May 2016. We arrived at the home at 10am and left at 6.30pm. The service had previously met all of the regulations we inspected against at our last inspection in November 2014.

The home provides personal care, support and accommodation for up to 35 older people who may also have dementia. Accommodation is provided on two floors, with lounges and dining rooms available on the ground floor. A passenger lift and stairs provide access to upstairs. At the time of the inspection there were 25 people residing in the home and another resident was in hospital.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection we identified one breach of the relevant regulations in respect of the secure storage and recording of controlled drugs . You can see what action we told the provider to take at the back of the full version of the report.

We found that whilst the administration, storage and disposal of other medications were safe, the provider did not have the correct systems in place for the storage and recording of controlled drugs. This meant that they were not stored securely and there wasn't a clear audit trail for all controlled drugs received into the home. However, this had no impact on the people who used the service. This had had no impact on the people who used the service, but posed a risk that errors could be made because controlled drugs couldn't properly be accounted for.

The experiences of people who lived at the home were positive.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People's needs were assessed and plans were developed to identify what care and support people required to maintain their health and wellbeing and foster their independence where possible.

People were protected from abuse. Staff were knowledgeable about the risks of abuse and reporting procedures. We found there were sufficient staff available to meet people's needs and that safe and effective recruitment practices were followed.

Staff had good relationships with people who lived at the home and were attentive to their needs. Staff respected people's privacy and dignity at all times and interacted with people in a caring, respectful and professional manner.

People's health care needs were met and their medicines were administered appropriately. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet people's needs. People were appropriately supported and had sufficient food and drink to maintain a healthy diet.

Staff received suitable induction and training to meet the needs of people living at the home. Staff were well supported by the manager. This meant people were being cared for by suitably qualified, supported and trained staff.

There were systems and processes in place to monitor the quality of the service. Audits were carried out and where shortfalls were identified the management were using the information to improve the service. This demonstrated that it was a learning organisation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not completely safe.

Medicines were administered safely but controlled drugs were not all stored or recorded correctly.

People were protected by staff who understood how to recognise and report possible signs of abuse or unsafe practice.

People were protected by safe and robust recruitment practices and there were sufficient numbers of staff to meet people's needs and keep them safe.

Is the service effective?

Good

The service was effective.

People were supported by motivated and well trained staff. Induction for new staff was robust and appropriate and all staff received effective supervision and support.

People's rights were protected. Staff and management had an understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the capacity to make decisions for themselves had their legal rights protected.

People were supported to have their health and dietary needs met.

Is the service caring?

Good

The service was caring.

The service provided care and support to people enabling them to live fulfilled and meaningful lives.

Kindness, respect and dignity were integral to the day-to-day practice of the service.

People were treated with respect by staff who were kind and

compassionate.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support, which was responsive to their changing needs.

People were actively encouraged to engage with the local community and maintain relationships that were important to them.

Complaints and concerns were listened to, taken seriously and addressed appropriately.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place who had been in post for 2 years. The staff were confident they could raise any concerns about poor practice and these would be addressed to ensure people were protected from harm.

There was a positive culture within the service and clear values that included involvement, compassion, dignity and respect. The provider and manager provided strong leadership.

People were included in decisions about the running of the service and were encouraged and supported to have their voice heard.

There were systems in place to assess and monitor the quality of the service. The quality assurance system helped to develop and drive improvement.

Rosevilla Residential 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 23 May 2016 and was unannounced. The inspection was carried out by two adult social care inspectors. We arrived at the home at 10am and left at 6.30pm.

Before the inspection we reviewed all the information we already held on the service. We looked at any notifications received and reviewed any other information held about the service. We invited the local authority to provide us with any information they held about Rosevilla Residential Home.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We observed how the staff interacted with the people who used the service and looked at how people were supported throughout the day. We reviewed three care records, staff training records, and records relating to the management of the service such as surveys and policies and procedures. We spoke with five people who used the service and relatives of two other people. We also spoke with the directors of the company that owns the home, the registered manager, the administrator, the cook and four care staff.

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 communicate with us because they were living with dementia.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home and the relatives we spoke with told us they felt the care was safe. When people were asked what they would do in the event that they felt threatened by anything or anyone, all felt confident that any member of staff would assist immediately.

The risk of abuse was minimised because there were clear policies and procedures in place to provide staff with information on how to protect people in the event of an allegation or suspicion of abuse. The registered manager informed us that staff undertook training in how to safeguard adults and this was confirmed by staff that we spoke with. Staff were able to explain to us the types of abuse that people were at risk of, who they would report this to and where the relevant guidance was.

We saw that the provider had a whistleblowing policy in place. Staff were familiar with the term whistleblowing and each said they would report any concerns regarding poor practice they had to the manager. All staff confirmed that they were aware of the need to escalate concerns internally and report externally where they had concerns. This indicated that they were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to accurately record and report potential incidents of concern.

We saw that staff acted in an appropriate manner and that people were comfortable with staff.

During our inspection we observed a senior carer administer medication to people. This was done safely. We looked at the medication records for three people; these indicated people received their medication as prescribed. Records showed that all staff who administered medication had been trained to do so. They also underwent regular competency assessments and supervised medication rounds to ensure that medication was administered correctly and safely. We looked at the medication storage facilities and found that some controlled drugs (CDs) were not stored or recorded properly. (CDs are classified (by law) based on their benefit when used in medical treatment and their harm if misused.) Some controlled drugs in injection form were stored in a locked cabinet but not in the CD cupboard, which is of a stronger construction and harder to open without a key. The staff at the home did not administer these injections, but were storing them for the district nurse to administer to some people who used the service when required. We also found that the CD register was not up to date and that some CDs that had been returned to the pharmacy were still showing as present in the home in the CD register. Therefore, there wasn't a clear audit trail of CDs received into the home.

This constitutes a Breach of Regulation 12(1) and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure the proper and safe management of medicines.

People said that staff met their needs and came promptly when called. Staff said that there were enough staff to provide a good standard of care. The registered manager told us that staff rotas were planned in advance according to people's support needs. We looked at the staff rotas and saw that, as well as the registered manager who was present in the home most days, there were always at least one senior and

three care assistants on duty from 8am to 10pm and usually one senior and one care assistant from 10pm to 8am (occasionally there were two care assistants on duty at night, but one would be more experienced). In addition the home employed an administrator, a cook and a domestic assistant every day.

The registered manager told us that all new employees were appropriately checked through robust recruitment processes. These included obtaining references, confirming identification and checking people with the Disclosure and Barring Service (DBS). We checked the staff files, which confirmed that all the necessary checks had been implemented before they had commenced working in the home. This helped to reduce the risk of unsuitable staff being employed.

We had previously received concerns that people were not protected from the risk of falls because falls were not analysed to look for causes or trends and risk assessments were not reviewed or updated when people's needs changed. We looked at falls risk management and found that individual risk assessments were completed for people who used the service and staff were provided with information as to how to manage risks and ensure harm to people was minimised. Each risk assessment had an identified hazard and management plan to reduce the risk. Staff were familiar with the risks and knew what steps needed to be taken to manage them. Records showed that staff took appropriate action following accidents or incidents.

We looked at the maintenance records. Regular environment and equipment safety checks were carried out, which included fire and water safety, environment audits, hoists and wheelchairs. Any issues regarding equipment safety were reported to the management, who arranged for a suitable contractor to visit the site. The service had a business continuity plan in the event of a significant incident which may include a power failure, flood or fire.

Staff received fire instruction on their induction and had fire safety training. Fire drills were carried out monthly. There were personal evacuation plans in the event of an emergency for all of the people who used the service.

The home was very clean and staff had received training in infection prevention and control. Anti-bacterial hand cleanser was available in the bathrooms. Liquid soap and paper towels were also available at all wash handbasins. One relative said "The home is always spotless, if anything is spilt they clean it up straight away".

Good

Is the service effective?

Our findings

Concerns had been raised about how special dietary needs were being monitored. Prior to the inspection, on 18 March, we visited to look at the care file for a specific person and found some shortfalls in the record keeping and monitoring, which we were subsequently told by the provider had been addressed. During the inspection we looked at this aspect of care.

People told us the food was good and they had plenty to eat. Comments included: "It's very nice" and "I enjoy it". Relatives said if they were there at mealtimes they were invited to join their relative for a meal and that the food was very good. All the people who used the service were asked their individual likes and dislikes. This information, together with any special dietary requirements, was shared with the service's catering and care teams. We observed lunch being served and saw that people were offered choices and were supported to have sufficient amounts to eat and drink. Staff helped people to eat and we observed staff taking time to talk with people and join in with conversations at the meal tables. Staff we spoke with had a good understanding of each person's dietary needs and their preferences. Anyone identified at an increased risk of malnutrition, dehydration, or who had significant weight loss had their diet and fluid intake monitored and recorded through the completion of the relevant monitoring charts and fortified diets were provided where appropriate. Everyone was encouraged to have their weight recorded at least monthly and those identified at an increased risk of malnutrition were encouraged to have their weights recorded fortnightly. The manager completed a weights audit monthly to ensure all actions had been completed and the appropriate professional involvement arranged when necessary.

The provider had policies and procedures to provide guidance to staff on how to safeguard the care and welfare of people using the service. This included guidance on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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 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 Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people in the home were subject to DoLS applications and we were able to view the paperwork in relation to these. However, we found that one person's authorisation had recently expired. We recommended that the manager set up a system to record the dates DoLS had been applied for, date of authorisation, any conditions and expiry date, which she did on the day of the inspection.

During our visit we saw that staff obtained people's consent before providing them with support. Staff we

spoke with during our visit were aware of DoLS and had received the relevant training.

Records showed that people received support with their health care. People had access to GPs, district nurses, dentists, opticians and chiropodists. Referrals were also made to other health care professionals, such as physiotherapist or speech and language therapist, as required. Where possible people were encouraged to choose who provided their healthcare services, and where possible people continued to receive support from those involved in their care prior to them moving to the service.

We spent time talking with staff about how they were able to deliver effective care to the people who lived at the home. Staff had a good knowledge of people's individual needs and preferences and knew where to find information in people's care plans. Some of the staff had worked at the home for some time and had got to know people's needs well.

We saw that staff had the skills to be effective in their role. Staff had received a comprehensive induction which covered the 15 Care Certificate Standards (The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.) Staff told us that they spent time working with more experienced staff, until they got to know people and were confident and competent to work unsupervised. We saw from the training matrix there was an ongoing programme of training applicable to the needs of people who used the service. Some staff had been identified as needing refresher training in certain topics and we saw evidence that this had been scheduled. All but four staff had completed dementia care training. Staff said they were not asked to do anything for which they felt untrained.

The provider's policy was that all staff should receive an annual appraisal and supervision every three months to ensure that competence was maintained. Staff meetings were held regularly and covered topics such as staffing levels, training and safeguarding, where the manager checked people's knowledge and understanding. Lessons learnt from inspection reports, audits, complaints and safeguarding alerts were discussed at staff meetings. These meetings also provided staff with the opportunity to express their views on how the service could improve the experience for those that live and work at the service.

Some adaptations had been made to the environment to assist people with memory difficulties to find their way around. The communal toilets and bathrooms were signed. Bedroom doors were all numbered and all had the appearance of external house doors. Outside of the bedroom doors there were frames/small boxes and some had different displays of items of interest or photographs to help people identify their room. Light switches in bedrooms were a different colour to the surrounding wall so people could see them more easily.

The home had a large ground floor lounge divided into smaller seating areas, two areas having large, wall-mounted flat screen TVs. There was also a large dining area divided into two rooms and a hairdressing salon. However, there was no quiet area where people could sit other than in their own rooms.

The home provided adaptations for use by people who needed additional assistance. These included bath and toilet aids, grab rails and other aids to help people maintain independence.

The ground floor lounge area had doors which led to an enclosed garden, which contained a patio area with plenty of seating, a lawn and flowerbeds. This garden was not secure because the fence was broken. A director of the company who owned the service said that they had not repaired the fence because of impending alterations to the property and grounds, but as this was taking longer than originally anticipated the fence would be repaired.

The manager and directors advised that they had recently attended a conference about the best practice in providing an environment suitable for people with dementia and they had recently obtained planning permission to expand and improve the home and garden.

We did note that there were a number of notices aimed at staff in bathrooms and bedrooms, which detracted from a homely environment. We discussed this with the management, who said they would review this practice and remove those that weren't strictly necessary.

Good

Is the service caring?

Our findings

People who used the service and the relatives we spoke with were complimentary about the staff. Comments included: "Each and every one of the staff I have met and spoken to go out of their way to be helpful and friendly"; "The staff are very nice, they take the time to get used to your ways"; "The staff are lovely".

There were a number of thank you cards that included comments such as: "I truly can't thank you enough for all your support for (x) over the last three years"; "Thank you for the loving care given to (x) during her short stay. We would especially like to thank you for the care, dignity and respect shown to her during her final hours".

People told us that friends and relatives were able to visit at any time without restrictions. The relatives we spoke with confirmed this and told us they were always made to feel welcome.

We saw that people who lived at the home and their family members were involved in planning their care. One relative said she had recently been involved in a review of her relative's care plan and a discussion about whether to resuscitate in the event of a cardiac arrest.

People's life history was recorded in their care records, together with their interests and preferences in relation to daily living. People's bedrooms were personalised and contained photographs, pictures and personal effects each person wanted in their bedroom.

We observed throughout our visit that staff assisted and supported people in a friendly and respectful way. For example, staff consulted people who needed assistance with their mobility in regard to their comfort when seated. We saw that staff were respectful, friendly, supportive and used people's preferred names. They continually interacted with the people in their care, either sitting and chatting or offering support and encouragement. People were comfortable and relaxed with the staff who supported them. We observed that one person who used the service was restless, so a member of staff took her for a walk. Another was unhappy with what she was wearing, so another member of staff took her to her room and helped her choose something else to wear.

The service took account of people's diverse needs. Staff we spoke with told us they enjoyed supporting the people living there and were able to tell us a lot of information about people's needs, preferences and personal circumstances. This showed that staff had developed positive caring relationships with the people who lived there.

People's right to privacy and dignity was respected. Staff explained to people who the inspectors were and asked people's permission to enter their rooms. People were able to spend some time alone in their bedrooms. One person who used the service said "There's plenty going on if you want to join in, but if you just want to rest in your room that's ok".

All new starters received training that included duty of care, privacy and dignity, and working in a person centred way, to provide them with the knowledge and understanding of their caring responsibilities. All staff had completed training to ensure that confidential, personal and sensitive data was protected.

End of life care could be provided at the service with the support of other professionals including the GP, community nurses and palliative care team. This ensured people's care needs could continue to be met whilst maintaining their comfort and dignity.

People were able to see visitors in private if they wished and were able to take visitors to their rooms.

Good

Is the service responsive?

Our findings

People said that the staff responded to them as individuals. People who used the service and the relatives we spoke with told us that the service responded well to people's needs and requests. One person said "Staff are very helpful, I choose what I want to do. I go out to bingo at the Catholic club every week. X (one of the directors) used to come with me but now a friend picks me up".

We asked whether call bells were responded to promptly. Overall people said staff responded quickly if they asked for assistance.

The care records we looked at showed that people's needs were assessed and they could visit before deciding if they wanted to move in. People's needs were reviewed again on admission and appropriate care plans were drawn up. Risk assessments were completed, which allowed staff to identify risks to the individual and measures the staff could implement to reduce the risk of potential harm in the least restrictive ways possible. Care plans were written in a person-centred way, included people's life history and were reviewed at monthly intervals or when needs changed.

The staff we spoke with were familiar with people's needs. The staff told us they had access to the care records and were informed when any changes had been made to ensure people were supported with their needs in the way they had chosen.

We saw that visitors were welcomed throughout the day and staff greeted them by name. Relatives we spoke with told us they could visit at any time and they were always made to feel welcome. They said they were consulted about their relatives' care and the staff were responsive to requests.

People were encouraged to maintain and develop relationships. People told us how they had made friends with other people who lived in the home. People were also encouraged to visit their family members and to keep in touch.

We found that there were a number of activities taking place in the home. The activities programme was displayed in pictorial form in the foyer and included card games, Zumba (exercise) twice a week, bingo, films and indoor bowling. They had advertised on the home's Facebook page for people to provide old wellies for people who used the service to put bedding plants in for the garden. There were photos of people enjoying activities and posters inviting family members to attend. On the morning of the inspection one of the senior carers was talking with people who used the service about their life histories to enable the service to provide people with activities that were of interest to them. This information was added to people's care files and staff were informed at handover of any new information. The senior told us that she did this every few weeks because the people who used the service remembered different things on different occasions and it enabled them to get to know people better. In the afternoon one member of staff was consulting with one of the people who used the service what music to put on and another was discussing with some other people recent football finals and planning social activities for the forthcoming Euros. Entertainers also came into the home. Staff said they took people out for walks sometimes and trips out to places of interest took place

occasionally.

People could have a television in their room, a telephone was available for people to use and newspapers and magazines were ordered on request.

The home had a complaints procedure that was displayed in every bedroom and people who lived at the home and relatives told us they would feel comfortable raising concerns and complaints. We looked at the complaints and compliments file. There had been three complaints last year, all of which had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

A positive culture was evident in the service where people who used the service came first and staff knew and respected that it was their home.

The home had a registered manager who had been in post at Rosevilla for 2 years. In conversation with the inspectors she demonstrated good knowledge of all aspects of the home including the needs of people living there, the staff team and her responsibilities as manager.

The directors of Rosevilla Residential Home Ltd were all members of the same family and were present in the home every day.

People's views on the quality of the service were regularly sought. Satisfaction surveys were carried out, which included questions about the standards of accommodation, care, activities and staff skills. At the last survey the home had scored 83% for customer satisfaction. The operations director analysed the surveys; she fed back the findings to staff and drew up an action plan to address any changes that could be made to improve the service.

The provider had tried various ways to involve relatives in discussion about the running of the home, including holding meetings and inviting them to events, but said that very few people turned up. They had set up a website and Facebook page to keep people informed and the manager said she tried to talk to relatives when they visited the home. The relatives we spoke with said they knew who the manager and directors of the company were and felt they could approach them at any time. One relative told us how he had appreciated one of the directors going through the residency contract with him.

All care staff attended daily handovers to ensure effective communication was maintained.

The registered manager said she regularly walked around the service checking the environment, staff interactions and behaviours and resident care and welfare. Regular quality assurance audits were also completed to assess the safety and performance of the service; these audits included medication, care plans, infection control and complaints.

Accidents and incidents were audited monthly to identify any trends. Where a person who used the service had had a number of falls we could see that their falls risk assessment had been updated and a referral had been made for a health assessment.

In addition to the above there were also a number of maintenance checks being carried out weekly and monthly. These included the fire alarm system and water temperatures. We saw that there were up to date certificates covering the gas and electrical installations as well as any lifting equipment such as hoists and the lift.

Periodic monitoring of the standard of care provided to people funded via the local authority was also

undertaken by Warrington Borough Council's contract monitoring team. This was an external monitoring process to ensure the service met its contractual obligations to the council. We spoke to the contract monitoring team prior to our inspection and they informed us that Rosevilla was currently subject to an action plan. The outstanding areas for improvement they identified were as follows: they needed to ensure that care plans and risk assessments were up to date. We saw that the home was in the process of updating all the care plans and risk assessments and the ones we looked at were current, although one care plan for a person who had not been in the home long could have been more detailed about how to manage the person's anxiety.

The staff we talked to spoke positively about the current leadership of the home. Staff told us that the registered manager listened and took action when they made suggestions or raised concerns, and they could approach the manager at any time for help and advice. Staff said they were well supported and had lots of opportunity to develop. When asked whether they liked working in the home, one person said "I love it" and another said "I'm happy here". When asked about the management, a staff member told us "They're brilliant and very supportive, I can approach any of them".

We had been notified of reportable incidents as required under the Health and Social Care Act 2008, apart from some recent DoLS authorisations. The registered manager apologised for the oversight and submitted them on the day of the inspection.

There was an on call system in place in case of emergencies outside of office hours and at weekends. One of the directors lived on the premises. This meant that any issues that arose could be dealt with appropriately.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some controlled drugs (CDs) in injection form were not stored in the CD cupboard and the CD register was not up to date. Regulation 12 (1) and (2)(g)