Sanctuary Care (England) Limited

Rushyfield Residential and Nursing Home

Inspection report

Rushyfield Care Centre, Brandon Lane
Brandon
Durham
County Durham
DH7 8SH

Tel: 01913784691
Website: www.embracegroup.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Rushyfield Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It provides personal and nursing care for 41 people some of whom are living with dementia. The home is on three floors serviced by a lift. People receive care on two of these floors and the kitchen, laundry and staff room are on the lower floor of the home. When we inspected there were 36 people living at the home.

This inspection took place on 23 August 2018 and was unannounced.

At our last inspection in August 2017 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. The home was meeting the requirements of the fundamental standards.

People, relatives and staff felt the service was a safe place. People were protected from the risk of abuse because staff understood how to identify and report it.

There were sufficient staff on duty to meet people's needs. We received positive feedback about staff always being available when people needed them and staff were visible throughout our visit.

People received their medicine safely and were supported to access the support of health care professionals when needed.

Where risks were identified to people who used the service or to the environment these were assessed and plans put in place to reduce them. Accidents and incidents were analysed to identify trends and reduce risks.

People's needs had been assessed both before and after their admission to identify their care needs.

Staff were well supported and received the training they needed.

People received a varied and nutritional diet that met their preferences and dietary needs. The service provided home-made food and drinks which were adapted for different diets.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they thought the service was caring. We received some examples of the service being very caring in the way it supported people and their relatives.

People told us, and we observed, that care was delivered with dignity and respect and people were supported to be as independent as possible.

Care plans were detailed and reflected people's needs and preferences. Care plans were evaluated regularly and included meaningful information about people's needs.

People were actively engaged in a range of activities and had opportunities to access the wider community.

People told us they did not have any concerns about the service but knew how to raise a complaint if needed. Feedback on the service was encouraged in a range of ways and was positive.

The management team were approachable and they and the staff team worked in collaboration with external agencies to provide good outcomes for people. Processes were in place to assess and monitor the quality of the service provided and drive improvement.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service has improved to Good.	**Good**

Rushyfield Residential and 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 was a comprehensive inspection. It took place on 23 August 2018 and was unannounced. This meant the provider did not know we were coming.

The inspection was carried out by one adult social care inspector and a specialist advisor with a specialism in nursing and dementia care.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send to CQC within required timescales.
We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service, the local authority safeguarding team, and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with five people who lived at Rushyfield Residential and Nursing Home. We spoke with the regional manager, manager, a staff nurse/deputy manager, a nurse associate, a team leader, two care workers, one agency care worker, one catering assistant, the cook, administrator and activities coordinator. We also spoke with five relatives and two visiting healthcare professionals.

We looked around the home and made observations of people and staff interacting. We 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 viewed a range of records about people's care and how the home was managed. These included the care records of four people, medicine administration records, recruitment records of four staff, training and supervision records and records in relation to the management of the service.

Good

Is the service safe?

Our findings

People and their relatives told us the service remained safe. One person told us, "I feel very safe". "Staff always make sure I have the buzzer near me, and they come as quick as they can if I press it." A relative we spoke with said "I know my [family member] is safe here, she was always falling at home but no falls here". Another relative told us, "It's the main reason I wanted [family member] to come in here, for her safety. She always has her buzzer."

Risks to people's safety were assessed and where possible actions taken to reduce the risk. Risk assessments covered people's moving and handling, skin integrity, falls, health and mental health risk. Relatives told us that equipment such as sensors and bedrails were used to help keep their family members safe. One relatives said, "I was happy with that because [family member] had fallen. It happened at home."

Risks to the environment continued to be safety assessed and plans were in place to mitigate these. For example, fire risk assessments were in place with personal emergency evacuation plans (PEEPS) for each person. Health and safety audits were completed and service and maintenance checks, such as for electrical testing, gas servicing and portable appliance testing records, hoists and lifts, were all up to date. The home analysed accidents and incidents to identify trends and put measures in place to reduce the risk of these recurring.

We observed there to be sufficient staff on duty to meet people's needs promptly. Staff's actions were purposeful but unhurried. No one we spoke with raised any concerns about the staffing levels. A person who used the service told us, "It's good, there is always someone about." One relative told us, "When buzzers go they are there straight away." The registered manager monitored staffing levels based on the dependency levels of people living at the home. This helped ensure staffing levels remained appropriate. A staff member told us, "We are very rarely short staffed, we try to cover sickness and holidays between us, it's very rare we use agency staff".

The provider still had safe recruitment procedures in place which were thorough and included necessary vetting checks before new staff could be employed. For example, Disclosure and Barring Service checks (DBS) and references. These were carried out before potential staff were employed to confirm whether applicants had a criminal record and are barred from working with vulnerable people. We saw there was a system for updating checks in-line with good practice.

Staff told us they knew how to recognise abuse, what action to take and how to report their concerns. Staff had received training in safeguarding and whistleblowing and told us they were confident about following the company's policies and procedures and referring to other agencies, such as the local authority safeguarding team. Where safeguarding issues were identified these were reported and investigated.

Medicines were managed safely. We checked medicine administration records (MAR) and observed people being given their medicines. Staff had received training and had regular checks to ensure they remained competent to administer medicines. People had Individual Medication Protocols in place, which included

date of last review, instructions on how a resident likes to take medication and information on medicines given covertly (medicines in a disguised form given without the person's consent) or PRN (medicines given as and when required such as for pain relief). Where medicines were given covertly, the appropriate people had been involved in agreeing this.

We found the home was clean and well maintained. We observed staff followed good infection control procedures, such as hand washing and the use of personal protective equipment (PPE). The home had taken steps to address actions made in a report from NHS infection prevention and control team, including purchasing new mattresses and gloves.

Good

Is the service effective?

Our findings

People's needs were assessed and support plans were created where needed. We found that staff adhered to these plans and regularly reviewed the effectiveness of the approaches they had adopted in line with legislative requirements and good practice. Individual choices and decisions were documented in the care plans and they were reviewed.

People and relatives told us they felt staff had the skills and knowledge to carry out their roles. One person told us, "Staff all seem to know what they are doing." A relative told us, "Yes, they definitely have" and "Staff know {family member quite well and how to look after her."
Staff received good support and had access to the training they needed. A member of staff told us, "We can ask for different things, we're offered more training, they never refuse us." Another said, "We have supervision, I've just had one. We discuss training and I'm up to date." The provider had identified essential training for staff as including equality and diversity, fire safety and moving and handling. Records showed staff had access to a range of training to meet people's needs and were regularly supervised and appraised.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Systems were in place to ensure appropriate DoLS applications were submitted to the assessing authority and to monitor when these were granted. We saw people had the required MCA assessments and best interests decisions in place. Staff had a good understanding of people's capacity and how to support them to make daily choices. We observed staff asked for people's consent before engaging in care tasks.

People were supported to have nutritional meals that were adapted for special diets such as diabetic, textured diets and for those people at risk of malnutrition. People told us they enjoyed the homecooked food and we saw that, as well as the choice available on the menu, people's preferences were catered for. One person told us, "If I don't like what's on the menu they always find me something else like sandwiches." Another said, "The food was very nice, excellent." Professionals were consulted with when risks were identified to ensure people had appropriate diets. One relative told us, "[Family member] had lost a lot of weight. They had the dietician in." Another relative said, "[Family member] went onto a special diet because they might choke." We observed that people were offered the support they needed to eat and drink and this was provided with patience and gentle encouragement.

Care records showed regular involvement from health professionals where risks were identified and to ensure people were living healthy lives. For example, there was involvement from the continence service, speech and language specialists, community psychiatric nurses and people had been appropriately referred to the community falls team when falls had been identified.

The home had been adapted to make it easier for people living with dementia to orientate themselves. For example, clear signage, areas of the home had been themed with murals on the walls and contrasting colours used for handrails and toilet seats. We saw that some people's bedrooms were identifiable because

they had a short profile of the person on the door. Some people also had 'memory boxes', which are small boxes filled with personal items chosen by the person or their families. The manager explained that the activities co-ordinator was working with families currently to ensure everyone had a memory box.

Good

Is the service caring?

Our findings

People and their relatives told us the service was very caring and had supported them with compassion. One person told us, "Staff are ok, I wouldn't say anything bad about them." Another said, "I like the staff. Yes, they are kind."

A relative told us, "The home has got better over the past few years. Staff are more caring, they really really care" and "I feel like I'm part of the family." Another relative told us, "I love this home and my relative being here. They go out of their way to care for her. They really care." Another told us, "Staff are really, really lovely, home is nice. I can't fault it. Very positive. They are really nice to everyone when they come in." A fourth relative said, "Staff are caring," then went on to say, "They are very good to me as well." This person had lunch in the home with their family member every day which the home had offered to them free of charge. Although the person had chosen to pay for their meals they told us they very much appreciated the offer and it made them feel welcome in the home. A district nurse we spoke with told us, "Staff are fabulous, really helpful… very caring."

We observed that staff had time to speak with people and relatives. On a number of occasions, we saw staff and relatives exchanging updates about people's wellbeing and care needs. A relative told us they could be as involved in the person's care as they wanted, including involvement in reviews with the person's agreement. Staff used people and relatives first names and appeared to have very comfortable and close relationships with them.

We were told that staff gave people and relatives both practical and emotional support. For example, a relative told us the manager attended a meeting with them and social work professionals in relation to a safeguarding concern. They said "[Manager] helped me a lot. She calmed me down and explained what was going on. She came to the meeting to be there for me." They went on to say that staff provided ongoing emotional support to their family member following this.

Staff treated people with dignity and respect. A relative told us, [Family member] is treated with dignity and respect all the time. They are lovely with her." We observed staff speaking with people in a respectful way, giving them time to answer questions and knocking before entering people's bedrooms. People told us that staff took time to explain things to them and we observed staff giving people guidance, for example about what items were on the table in front of them or redirecting people if they seemed unsure of where they were going. One person told us, "I have very poor eyesight and 'the girls' always explain what is happening or going on."

People were supported to be as independent as possible. We asked people if they felt staff supported their independence. One person told us, "Yes, I think so, just enough. Staff are there and can help if needed." We saw care plans gave staff instructions on how to support people to do as much for themselves as possible.

People were supported to access advocacy services when needed. Advocates help to ensure that people's views and preferences are heard.

Good

Is the service responsive?

Our findings

People had person centred care plans that were tailored to meet their individual needs and preferences. People's life histories were documented as well as their aspirations for the future. People and relatives told us care was delivered in the way they wanted and needed it.

People had opportunities to personalise bedrooms to make them homelier. One relative told us, "We got [family member] new quit covers, the manager said 'you can do anything you like. It's their home." Another relative told us, "We brought a chair in from home, they were very accommodating."

People were given clear explanations in relation to their care and staff had access to a range of information in accessible formats to suit people's needs, such as braille or easy read. Information was also available in other languages.

The home had a plan of activities which was flexible to people's choices and covered every day of the week. This included pet therapy, one to one activities, singers and volunteer groups visiting people in the home. There was also access to a minibus so that people could access the wider community and people had recently been to the garden centre with a view to developing the outside space at the home. The activities co-ordinator also told us the home had links with schools and community groups.

People and relatives, we spoke with were confident about the way their concerns and complaints would be addressed. No one raised any concerns with us during our visit and told us if they did have concerns they would report them straight away. One relative told us, "I have no reservations about anything, if I did I could just go and speak to the manager", and this was typical of the responses we received. We saw that very few complaints had been received but there were policies and procedures to ensure that these were responded to in set timescales.

Although no one was receiving end of life care at the time of our visit we received extremely positive feedback from one relative whose family member had recently passed away in the home. They told us that staff had stayed with their family member even though this had meant staff coming in on their day off or other staff working far beyond their normal working hours until the early hours of the morning. They went on to explain that staff had called Marie Curie nurses because the doctor could not come out straight away to sign the death certificate, that the family had been offered food and accommodation in the home and that staff had attended the person's funeral. The relative told us, "I can't thank them enough." They also said, "It means such a lot to me. I always come to see them and it makes me feel better."

Good

Is the service well-led?

Our findings

At the last inspection we found that the home was not always well-led because it did not have a registered manager in post and we rated it as Requires Improvement. At this inspection we found that improvements had been made and the rating has improved to Good.

At the time of this inspection the manager had applied to be the registered manager and their application was being processed. 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.

Everyone we spoke with on the day of our visit spoke highly of the management of the home and no one raised any concerns with us. People and relatives told us that they felt the home had improved in recent years and they were positive about the atmosphere and décor in the home. One person said, "I think it's very good, the best on offer." A relative told us, "I would definitely recommend here for anyone." Another relative said, "[Family member] couldn't be happier with the home, the staff are very caring, always a happy atmosphere."

Staff told us they liked working in the home and felt supported by the management. One staff member told us, "It's the quality of care they give everyone and the staff are caring. They support you, we get good support." This staff member told us management had been flexible and accommodating when they had to attend health appointments. Another staff member said, "This is a happy home, all one big family…our manager is very approachable and visible". Another told us, "The door is always open, you can go and speak to them at any time."

We also spoke with the regional manager who was in the home to have a supervision session with the manager. They told us they had confidence in the manager, stating, "She's a good manager, she's done a good job here." Both the manager and regional manager were enthusiastic about developments in the home and said they felt they were well supported by the wider organisation. One of the key developments had been improving care files to be more person centred with a view to moving to an electronic care records system. Improvements were being made to the gardens of the home with the assistance of Army cadets.

People were regularly asked their views on the service through meetings, questionnaires and feedback forms. For example, we saw that people had been consulted on improvements in the home. Recently people had helped choose the colour scheme for one of the lounges. One person told us, "The lounge is lovely, better than it was before. We put in what we thought we'd want in it."

Staff were regularly consulted and told us they felt they could influence decision making in the home. They were given opportunities to learn from good practice and develop their skills. For example, the home had four champion roles covering dignity, infection control, dementia and safeguarding. A champion is a member of staff who takes the lead on a subject and supports other colleagues to have current knowledge

in this area. Staff involvement was praised and there was an internal award scheme to recognise staff achievements.

There was a comprehensive auditing process in place which covered all aspects of the service. Checks were scheduled and completed on a regular basis and the outcome of these monitored centrally by the organisation. The home had recently had an internal quality assurance audit from their quality department and had scored 99%. The manager had shared and celebrated this positive outcome with staff.

We discussed recent external audits with the manager, such as a visit completed by the local authority, and saw that steps were being taken to learn from improvement points raised.

Since the previous inspection there had been changes to many of the policies and procedures in the home, some of which were still being cascaded down to staff. We saw there were avenues for staff to discuss policies and key policies were prominently displayed around the home, as were reference documents. These included the local authority's safeguarding procedures and good practice from the Department of Health.

The home had made links with local community groups such as schools and groups run at a local community centre. The service worked in partnership with many agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. For example, the manager attended a provider forum organised by the local authority.

The manager had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.