Roseland Care Limited

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Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**

Overall summary

This focussed inspection took place on 30 July 2015 as a result of information of concern received by the Care Quality Commission and the local authority. We received concerns that some staff may not have been treating some people in a safe and caring manner. These concerns are being investigated both by the service and an external agency.

The last inspection took place on 18 March 2015. There were no breaches of the legal requirements.

This report only covers our findings in relation to the 'Safe' and 'Effective' domains covered in this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roseland Care Limited on our website at www.cqc.org.uk

The Penlee unit is part of Roseland Care Limited which is a large care home providing care and support for older people. The Penlee unit provides care and support for up to 18 predominantly older people. At the time of the inspection there were 11 people living at the service. Most of these people were living with dementia.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service were not satisfied with the conduct of a member of staff. A meeting which took place in February 2015 had agreed to move the staff member to another shift so that they could be monitored. This action did not

Summary of findings

take place. Although there had been concerns about this staff member no specific action was taken. Following this inspection action was taken by the provider to resolve this issue.

We looked at how medicines were administered. We found that people had received their medicine as prescribed. However, there were handwritten entries on the medicine administration records (MAR) where medicines had been entered following advice from medical professionals. The transcribed entries had not always been signed by two staff to help reduce the risk of errors.

The service had identified the minimum numbers of staff required to meet people's needs and these were being met. However, staff told us they did not feel there were enough staff in the afternoons when two care staff were on duty. Six of the 11 people on the unit required two carers to meet their needs safely. When staff were supporting these people in their rooms, it left no staff available to support others who may need assistance. We discussed this with the provider and the registered manager who said they would increase the staffing levels in the afternoons to meet this need.

Staff were supported by a system of induction, training and supervision. More specialised training specific to the needs of people using the service was being provided, for example to provide dementia care. However, some staff had undertaken a short IT based course on this subject, which had not always been effective in providing staff with the skills and knowledge required to meet people's complex needs.

Staff meetings were held. These allowed staff to air any concerns or suggestions they had regarding the running of the service. However staff told us these meetings were not held regularly.

Staff were aware of the different types of abuse and were clear on how they would raise any concerns they had with the management of the service. However, staff were not clear how they would raise concerns outside of the service and were also not aware Cornwall Council were the lead authority for investigating safeguarding concerns. Staff were aware of the whistleblowing procedures, but some staff were not aware that it enabled them to raise concerns outside of the service anonymously.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Staff were available to support people with their meals if required.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the provider. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence would be reduced.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we told the provider to take at the end of this report.

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?

The service was not entirely safe. Some medicine records were not clear for staff to safely administer medicines.

This inspection identified there were not sufficient numbers of staff at all times to meet people's needs.

Staff were aware of how to raise any concerns they may have regarding any potential abuse.

Requires improvement

Is the service effective?

The service was not entirely effective. The management of the service was not effective.

The service did not always follow the guidance laid down in the Mental Capacity Act 2005.

People had access to healthcare professionals to meet their needs.

Requires improvement

Roseland Care Limited

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 checked 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.

The unannounced inspection took place on 30 July 2015 The inspection was carried out by three inspectors.

Before the inspection we reviewed the information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with the provider, the registered manager, the unit manager, the deputy manger, and five staff. People we met who were living at the Penlee unit were not able to give us their verbal views of the care and support they received due to their health and dementia care needs. We looked around the premises and observed care practices. Following the inspection we spoke with one family of a person who lived at the Penlee unit , visiting healthcare professionals and two further staff.

We used the Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at care documentation for three people living at the Penlee unit, medicines records for eleven people, staff files, training records and other records relating to the management of the service

Requires improvement

Is the service safe?

Our findings

People who lived at the Penlee unit were not able to communicate their views and experiences to us due to their healthcare needs. We therefore observed care provision using our Short Observational Framework for Inspection (SOFI). This helped us to understand the experiences of people who used the service. It enabled us to observe people's care and treatment and staff interactions with people.

The family of one person told us, "There is some very good care but there are also some staff who are not always caring and respectful." A visiting healthcare professional told us; "I have no concerns, they always call us appropriately".

During the inspection we saw most people's needs were usually met quickly. However, one person, who did not use the call bell, was heard crying out; "Please help me, I am so frightened" from their room for a period of 25 minutes before care staff entered their bedroom to assist the person. Inspectors saw staff were busy and four staff came and left the vicinity of this person's room, during the 25 minutes, but they did not react to the person's calls. We asked staff about this person, they told us the person was inclined to be 'very anxious' when left alone. This meant staff were not addressing this person's known anxiety.

Care plans contained risk assessments for a range of circumstances including moving and handling, nutrition and the likelihood of falls. Risk assessments were regularly reviewed to take account of any changes in people's needs. Where a risk had been clearly identified there was guidance for staff on how to support people. This was in order that risk was minimised and to keep people safe whilst maintaining as much independence for people as possible. For example, one person who was at risk from falls had a 'falls diary' kept and advice had been sought from external healthcare professionals to address the issue. Some people required to be moved using equipment. The equipment, along with the size of the sling to be used, and how many staff were required to carry out the care, was clearly specified for staff. However, another risk assessment for a person who had a history of falls and was at risk of further falls stated; "(the person) is to be assessed every time they need to mobilise to ensure they are steady enough to mobilise with a frame." This person was seen moving around the lounge and corridors of the service without support and without the use of a frame. The person was carrying two sticks, which they were not using, and had a glass of water in their hand. This meant staff were not following the guidance in the care plan and the risk of this person falling had not been reduced .

Where there had been concerns, or changes in a person's needs identified, external healthcare professionals were called in to assess the person. In one care file we saw clear guidance and advice had been documented. This informed staff how to provide support for a person, to try to reduce incidents where they exhibited behaviour that challenged others. However, this advice was not known to all staff and not always carried out. This meant the person continued to exhibit behaviour that challenged others and staff .

This contributed to the breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw from the staff rota there were three care staff in the morning and two in the afternoon supported by a manager on each shift. There were two staff who worked at night. Shifts were from 8am to 2pm and 8am to 8pm, with night staff working 8pm to 8am. Staff told us they felt they were a good team and worked well together. The service had identified the minimum numbers of staff required to meet people's needs and these were provided. However, staff told us they did not feel there were enough staff in the afternoons when only two care staff were on duty. Six of the 11 people on the unit required two carers to meet their needs safely. When staff were supporting these people, it left no staff to support other people who may need assistance. We observed periods of time throughout the inspection when several people who lived at the service, were present in the lounge and there were no staff present to assist them if needed. Most people were not able to access call bells independently due to their healthcare needs. We discussed this with the provider and the registered manager who said they would immediately increase the staffing levels in the afternoons to three staff.

We observed one staff member administering medicines in the lounge area during the morning of this inspection. The staff member provided clear information and instructions to people about their medicines for example; "These are your chewy ones". We saw medicines were administered in a kindly manner. One person required eye drops to be administered. The person told the staff member that the drops irritated her eye. The carer said; "Don't rub it, we'll have it looked at later."

Requires improvement

Is the service safe?

We reviewed the medicine administration records (MAR). We found that people had received their medicines as prescribed. There were no gaps on the MAR. One person was prescribed sedative medicine, which was to be given as required (PRN) to calm them. PRN medicine was not administered regularly and was reviewed by the GP regularly. However, there were handwritten entries on the MAR where medicines had been entered by staff following advice from medical professionals. The transcribed entries had not always been signed by two staff to help reduce the risk of errors. Staff had re-dated the MAR by hand on several occasions. One person's medicine records had been re-dated twice on the same page, but not in the same manner. The column for one date did not correspond with the same date lower down the chart. This meant staff did not have clear information with which to administer medicines and there was a risk of potential errors. We discussed this with the senior carer on duty and the unit manager, who assured us this would be amended immediately.

Regular medicines audits were carried out at the service, which identified if errors occurred. We saw that 'missing signatures' had been noted in the June 2015 audit. We asked the deputy manager what action had been taken in this regard, we were told; "We monitor it and will repeat the audit in the next cycle, if it continues we will do something." Missing signatures on the MAR had been noted at this inspection. This meant the audit process had not been effective.

The care records for people who used the service were held in the office in an unlocked filing cabinet which was not secured when we arrived, and throughout the inspection. The office was immediately inside the front door to the unit. The door to the unit was operated by a secure key pad entry system. The deputy manager told us; "I have never known this office locked." This meant people's confidential personal information was not kept securely. However we did not find that any person's confidential information had been inappropriately accessed.

The above contributed to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were aware of the different types of abuse and were clear on how they would raise any concerns they had with the management of the service. Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. There were "Say no to abuse" leaflets displayed in the service. These contained the phone number for the safeguarding unit at Cornwall Council. However, staff were not clear how they would raise concerns outside of the service and were not aware Cornwall Council were the lead authority for investigating safeguarding concerns. There was a whistleblowing procedure displayed on the wall in the office. Staff were aware of the whistleblowing procedures, but some staff were not aware that it enabled them to raise concerns outside of the service anonymously. The staff had been upset and surprised by the information of concern raised to CQC and told us they had never heard, or seen anything, that had concerned them regarding care provided for people at the Penlee unit.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the provider. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence would be reduced.

Requires improvement

Is the service effective?

Our findings

A visiting healthcare professional told us; "I have always found they follow our advice". Some staff told us they felt they did not always have sufficient knowledge and skills to meet people's complex needs.

The management responsibility for the Penlee unit was held by the deputy manager of the service at the time of this inspection. The deputy manager had only been in post for a few months. The service had been made aware of the concerns received by the Care Quality Commission and the local authority a few days before our visit. The deputy manager told us they were not familiar with the Penlee unit and they had not worked any shifts on the unit, as they were based in the main part of the service.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make specific decisions, at a specific time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. We saw families had been asked to sign family members care plans in agreement with the contents and were involved in care decisions. Staff told us there was a person who lived at the service who "hates water" and "dislikes showers." They told us; "Water is the trigger" and "We have to shower them sometimes to clean them up when soiled" All staff knew the person did not like being showered. We checked this person's care file for any records of how the decision to shower the person, despite knowing they did not like it, had been made. We did not see records of a best interest meeting that led to this care decision. This meant staff were not considering the MCA legislation and were not always acting in the person's best interest when providing care.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager was on sick leave and the unit manager was on annual leave. However, both the registered manager and the unit manager arrived at the Penlee unit during our inspection. Both told us they wished to be present and assist with the inspection process. We discussed the information of concern raised to CQC and the local authority. Following these concerns having been raised, the provider had put additional management cover in place 24 hours a day for the next ten days, using managers from elsewhere in the organisation. The management team told us about one staff member whose past conduct they had not been satisfied with. A management meeting which took place in February 2015 had agreed to move the staff member to another shift pattern so that they could be monitored by the service. This action did not take place. There had been concerns raised about this staff member, however, following an investigation by the management and an external agency no action had been taken. Following this inspection, action was taken by the provider to resolve this issue.

The service was not effectively assessing, monitoring and mitigating the risks relating to people who lived at the Penlee unit.

The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were supported by a system of induction training and supervision. More specialised training specific to the needs of people using the service was being provided, for example dementia care. However, some staff had only undertaken a short IT based course on this subject. Staff told us this had not always been effective in providing them with the skills and knowledge required to meet people's complex needs. Other staff had undertaken a three month course in dementia and felt they had the skills and knowledge to meet people's needs. Some staff were able to clearly explain to us strategies they adopted, to try to calm and settle people who became agitated and anxious. The provider confirmed that due to the concerns that had been raised regarding the care provided by some staff, additional classroom based training sessions on safeguarding adults and dementia care had been arranged.

We observed the lunch time period in the dining room. Food for the people in the Penlee unit was prepared in the main part of the service and delivered to the unit. Sandwiches and snacks were able to be prepared on the unit as required. Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Staff were available to support people with their meals if required. We saw from care files people's weight was regularly monitored to ensure people had sufficient nutrition.

We toured the service during our inspection. The décor was in good condition and all furnishing looked clean. There was a sensory room providing different types of lighting

Requires improvement

Is the service effective?

stimulation for people. Further stimulation activities were given in another lounge area through the use of an old fashioned typewriter, telephone and musical keyboard. The service had been enhanced to support people who required orientation to their surroundings. For example, there were pictures on doors to help people recognise various rooms such as the dining room, bathroom and toilets. There was a large clock face showing the date, day and temperature conditions. Handrails around the walls in the corridors supported people when moving around the service. There were no offensive odours in the communal areas of the service.

People had access to healthcare professionals including GP's, opticians and chiropodists. Care records contained records of any multi-disciplinary meetings that had taken place to discuss peoples health and social care needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with the requirements. The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and other who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. The service should design care or treatment with a view to achieving service users preferences and ensuring their needs are met, enable and support relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Regulation 9 (1) (a) (b) (c) (2) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.