Astley Care Homes Limited

Rosevilla Nursing Home

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**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 13 January 2017. We found that the service was not consistently safe, effective, caring, responsive or well led. We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of the report.

There was 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.

Rosevilla nursing home provides nursing care for up to 40 people. Six of the places at the service provided people with short term care of a period of up to three weeks. These places offered rehabilitation following a hospital discharge.

People's medicines were not always managed safely. Risks of harm to people were assessed however precautions were not always put in place to minimise these risks.

The principles of the Mental Capacity Act 2005 were not always followed as people who lacked the capacity to consent to their care at the service were not supported to consent in their best interests.

People were not always treated with dignity and respect and their right to privacy was not always considered.

People's care records did not always reflect people's current needs and measure progress towards agreed goals.

The systems the provider had in place to monitor and improve the service were not always effective.

People were supported by sufficient staff to meet their needs safely, who had been recruited using safe recruitment procedures to ensure they were of good character. Staff told us they felt supported and received training to be able to fulfil their roles.

People knew how to complain and had confidence that their complaints would be dealt with and there was a range of hobbies and interests available to people if they chose to participate in these.

People had a choice of foods and special diets were catered for. People had access to a range of health care agencies if they became unwell or their needs changed.

People who used the service and the staff told us that the registered manager was supportive and

approachable. The provider had continued plans in place to improve the environment for people.

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 consistently safe.

Risks of harm to people were not always assessed and acted upon. People's medicines were not always managed safely.

There were sufficient staff to meet people's care needs, however staff told us they didn't have time to spend quality time with people.

People were safeguarded from the risk of abuse as staff recognised and reported abuse appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA 2005 were not always followed to ensure people were consenting to their care and treatment.

Staff told us they felt supported and received training to be able to fulfil their role effectively. However staff would have benefitted from more supervision.

Accurate records of what people had to eat and drink were not maintained to ensure people were not at risk of malnutrition. People were offered food and drink that they liked and met their specific needs.

There was a range of health care services available to people when they became unwell or their needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect and their right to privacy was not always considered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not reflect people's current needs. Staff caring for people did not always have the information they needed to support people.

There was a complaints procedures and people we spoke with felt able to complain. The registered manager investigated complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems the provider had in place were not effective in monitoring and improving the quality of the service being provided.

People who used the service and the staff found the registered manager was supportive and approachable.

Rosevilla 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 13 January 2017 and was undertaken by two inspectors.

We looked at notifications the registered manager had sent us of significant incidents. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with eight people who used the service and three visiting relatives. We spoke with the registered manager, the operations manager, two nurses, the cook and three members of care staff. We spoke with a visiting health professional who supports people at the service.

We looked at the care records for six people who used the service. We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incidents, accidents and complaints records and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

Risks of harm to people were not always assessed and minimised in a timely manner. We saw that one person's care plan stated that they were at high risk of falls. The registered manager told us they had previously fallen and broken a limb. We saw the person was in their room in bed or sitting on their chair most of the day. A nurse told us that the person got themselves in and out of bed often through the day. We could not see what precautions had been taken to reduce the risk of this person falling. We saw that the person was getting themselves in and out of bed frequently. A comprehensive risk assessment was not in place to minimise the risk of the person falling. Assisted technology in the form of a sensor mat had not been considered to alert staff to the person moving from their bed or chair. This meant that this person was at risk of falling due to the risk of falling not being reduced through an effective risk assessment.

Another person told us they were sore lying in bed. The person's relatives told us that a sore area had been identified and a nurse had applied a dressing to a pressure sore area the previous day. However no risk assessment had been put in place to instruct the care staff on how to care for the pressure area. For example, there were no instructions for staff to reposition the person in bed regularly to prevent the sore deteriorating or when to change the dressing. We spoke to a visiting health care professional on the day of the inspection who arranged for an assessment by another health professional the same day. Precautions were then put in place in the form of a specialist mattress and a plan of care for staff.

We looked at the way people's medicines were managed. We found that some people's medicine stocks did not balance with their medicine records. For example, one person was prescribed an as required (PRN) medicine for anxiety. The prescribing instructions stated they could have up to three tablets a day. We saw that the person was having the medicines on a daily basis but it was not recorded how many tablets they were having at the time they were administered. The provider was unable to account for the numbers of this person's anxiety medicines and it was unclear how much of this medicine had been administered as the nurses did not record the amount of tablets given. This put this person at risk of being administered too much or not enough medicine when they were anxious.

We found that one person's medicine for the treatment of their diabetes had not been dated when it had been opened. The medicine had been prescribed at a date which would have meant that the medicine was out of date if it had been opened on that date. This would have meant the medicine was not safe to use. We found one person had topical cream in their room with a worn out prescribing label on. It had no name or instructions for use recorded on the tube. This meant that the staff could not be sure it was the person's cream and the how and when to apply it. We looked at people's medication administration records (MAR's) and saw that there were some gaps in the signatures of the nurses who had administered the medicines. Several people's medicines were not signed for on the day of the inspection and when we pointed this out to the nurse, they signed them retrospectively.

The above issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they generally didn't have to wait long to have their care needs met. One person told us: "The staff are very helpful, they come as quick as they can". Another person told us: "The staff come quick as a rule". However we observed that call bells were ringing nearly constantly all morning. One person told us: "It's not too bad here, but the buzzers drive me mad". Staff we spoke with told us they felt there was enough staff to meet people's needs in a timely manner. A member of staff told us: "This is a good day, the buzzers are constantly going. We get things done but we don't have time to spend quality time with people". We discussed this with the nurse on duty and the registered manager who told us that they felt it was the people who were on the short stays that tended to use the call bells more often for support than the permanent residents. From our observations we did not see people have to wait for an unreasonable amount of time for their care needs to be met. However, we discussed with the registered manager the consideration of the ever changing needs of people using the service and their dependency and that staffing levels should be altered accordingly.

We looked at the way that new staff were recruited into the service and found that staff employed by the service had been checked for their fitness to work with people who used the service. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

People were safeguarded from the risk of abuse as staff and the registered manager knew what to do if they suspected someone had suffered abuse. A member of staff told us: "I have reported abuse before when a relative was abusive to a person living here". Another member of staff told us: "I would report anything suspicious to the nurse or the manager. If no one did anything I would go higher if I had to". The registered manager followed the local safeguarding procedures and had reported potential abuse to the local authority when they had suspected someone had been abused.

Requires Improvement

Is the service effective?

Our findings

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. We saw that one person had been asking to go home and they lacked the mental capacity to agree to being at the service due to them living with dementia. When people are unable to consent to their care at the service due to their mental capacity to agree a referral for a Deprivation of Liberty Safeguards (DoLS) authorisation should made to the local authority. The DoLS are part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We discussed this with the registered manager who recognised that there were some people for whom referrals had not been made. This meant that these people were potentially being unlawfully restricted of their liberty.

We saw that one person had a Do Not Attempt Cardiopulmonary Resuscitation order in place (DNACPR). We saw that it was signed and agreed by the person's GP only. The person themselves or their legal representatives had not been involved in the decision to this order being put in place. This meant that this person had not consented to this decision or been supported to consent in their best interests.

People told us they liked the food and we saw that they had choices at meal times. One person told us: "The meals are beautiful", another person said: "The food is marvellous". People's specific dietary needs were met and special diets such as pureed diets and a vegetarian diet were catered for. If people lost weight or were having difficulty in eating they were referred for health care advice. However, some people had been assessed as being at high risk of malnutrition or dehydration and had recording charts in place to monitor the amount of food and fluids they had. We saw that these records were not always checked regularly by staff to ensure that people were eating and drinking enough. This meant these people were at risk of malnutrition and dehydration.

There were a range of health care agencies involved in people's care and support and the registered manager referred people when their needs changed. For example people saw their doctor, district nurses and occupational therapists when they needed to. We saw one person had become unwell and had been refusing support. The registered manager and staff had respected this choice; however they had referred the person to a community psychiatric nurse (CPN) for a full assessment of their needs. The CPN was supporting the person and the staff to best meet the person's needs.

Staff we spoke with told us they felt supported by the registered manager and received training to be able to fulfil their role effectively. One member of staff told us: "We have our appraisals due anytime now and there is lots of ongoing training". However we observed some staff practice which the registered manager had not identified through supervision previously although when we discussed this with the registered manager and operations manager they were aware of issues which may had affected the staff members' performance.

Requires Improvement

Is the service caring?

Our findings

We observed that not all interactions between staff and people were respectful in their nature. We overheard a member of staff saying to a person: "Will you stop getting in and out of bed, like a yoyo, what's matter with you"? This was said in an abrupt manner and did not demonstrate a caring nature. We looked at the person's care plan and it stated this is what the person did when they spent time in their room. This meant that this person's choices were not being respected and they were not being spoken to in a respectful manner.

We saw another person use their call bell not long after previously ringing it for staff support. We heard a member of staff say to the person: "You've just been to the toilet". The staff member then turned to us and said: "They are so demanding" and "She has dementia". This was said in the corridor directly outside of the person's room and the person and other people would have been able to hear. This meant that this person's right to privacy was not respected and they were not being spoken about in a respectful manner.

When we arrived at the service we saw that all bar one bedroom door was open. Some people were sitting in the nightclothes waiting for support to get dressed and others were asleep in bed. We saw there were several workmen in the building and the homes maintenance person walking in the corridors. Visitors were coming and going and people and their rooms were easily visible. We asked the registered manager and operations manager if having the doors open was people's choice and they told us that one person always had their door shut but other people's views on this had not been sought. We saw that due to the doors being open that staff did not knock before entering the rooms. This meant that people's right to privacy had not been considered.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us that people who were in the service for rehabilitation required more support than the permanent residents in relation to ringing the call bells and asking for support. Two people who were at the service for rehabilitation told us they did not feel that they were always kept up to date with when they may be going home and this caused them to become anxious. We discussed this with the registered manager who assured us that they kept people as up to date as they were able to in regards to their progress towards going home.

People who used the service told us that staff treated them well. One person said: "The staff are very kind". We observed most interactions between staff were kind and caring and most staff spoke kindly and respectfully to people. One person who used the service told us: "I like it here; it's like a big family". Relatives and friends were free to visit and we saw lots of visitors on the day of the inspection.

Requires Improvement

Is the service responsive?

Our findings

People coming into the service for rehabilitation were often admitted quickly due to them being at hospital and the hospitals requiring them to be discharged. An assessment of the people's needs would be sent to the service to be agreed that they could meet the needs of the person. However care plans and risk assessments were either not in place or not up dated with the relevant information on people's needs as staff identified a change. One person had developed a pressure sore; however a care plan had not been put in place to inform staff how to care for the person with the sore. Another person was refusing personal care; however there was no care plan to inform staff how to support this person when they refused their care. This meant that staff did not have the information they required to be able to respond to people's individual needs. Some records were not completed accurately, for example food and fluid intake was not always monitored so they would not give a true reflection of what people were eating and drinking and what risk this might present.

The staff supporting people who used the service for rehabilitation had limited information available to them to be able to support them in becoming well again. Records of people's progress towards going home or whether they may require care in another setting were not maintained. This meant people were not always aware of their discharge plans . A health professional who supported people at the service who were there for rehabilitation told us that they kept separate records as did the district nursing team. The registered manager told us that staff met every week to discuss people's progress however this would have been difficult to measure accurately with no accurate progress notes.

There was a staff handover of information at the beginning of every shift. This was to inform staff of people's changing needs and clinical up dates. However, two members of staff we spoke with did not know the name of one person who had recently been admitted into the service. This person required their medicine administered at specific times. When we asked about this person's medicines neither staff member could remember the person's name as to who this medicine related to.

On the day of the inspection people were being cared for in their rooms due to an infection outbreak. However we were told that some people usually spent time in the lounge area and there was an activity coordinator who encouraged people to become involved in hobbies and activities of their liking. We saw that the service was being decorated and adapted to support people living with dementia to orientate to time and place.

People we spoke with knew how to complain. One person told us: "I would speak to [Registered manager's name]; she asks me how I am often". We saw the complaints procedure was visible in the hall and we saw that the registered manager investigated complaints accordingly.

Requires Improvement

Is the service well-led?

Our findings

There were several audits in place to monitor the quality of the service however they were not always effective. For example the medication audit had not identified what we found on the day of the inspection in relation to the safe management of medicine. The registered manager could not be sure that people had their medicines as prescribed and that they were safe to use.

We found that records relating to people's care were not always reflective of people's needs. Records relating to people's food and fluid intake were not monitored to ensure that people were receiving sufficient amounts of food and drink. We found that when people's care needs changed their records were not always up dated to inform staff of their current care needs. This put people at risk of not receiving care that was safe and met their needs.

Records relating to people who were at the service for rehabilitation did not reflect the progress they had made. There was no information for staff to be able to support people to work towards their agreed goals. This meant these people's progress was not being monitored to ensure their health and wellbeing was improving.

There was no system in place to monitor the DoLS process and to ensure that people who used the service were not being unlawfully restricted at the service. We found that some people were potentially being unlawfully restricted as they lacked the mental capacity to consent to being at the service and no authorisation had been applied for.

Although staff had annual appraisals, they told us that there were no regular formal or informal supervision of their practice. We observed that not all staff spoke to people in a dignified manner. This may have been identified previously if supervision of staff was regularly undertaken.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and the staff told us that the registered manager was approachable and supportive. The provider had made several improvements to the environment, this included purchasing new furniture and equipment. There were on-going plans and works being undertaken to improve the environment for people and the registered manager discussed plans to implement systems to delegate nursing staff tasks which would improve the overall quality of the service. For example, identifying a named nurse to manage the rehabilitation service users.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and their right to privacy was not always considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving care that was consistently safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor and improve the service were not always effective.