C N V Limited

Rosecroft Residential Care Home

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 July 2014 at which breaches of legal requirements were found. We took enforcement action and served a warning notice on the provider in respect of a serious breach requiring them to become compliant with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations by 10 October 2014. The provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 20.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Rosecroft Residential Care Home' on our website at www.cqc.org.uk'

We undertook this focused inspection on the 6 November 2014 to check the provider had complied with this regulation.

This report only covers our findings in relation to the follow up on the breach of regulation 20 for records. We have asked the provider to send us an action plan telling us how and when they will become compliant with the other breaches. These breaches will be followed up at our next comprehensive inspection of the service.

Rosecroft Residential Care Home is located in the London Borough of Bromley and is registered to provide accommodation and personal care for up to 20 older people most living with dementia.

At our focused inspection on the 6 November 2014 we found that action had been taken by the provider to improve the care plans and records referred to in the warning notice. The home had implemented a new electronic care plan system which detailed people's needs and risks and provided staff with guidance to support people to meet their identified needs. Care plans we looked at were comprehensive and up to date.

Records relating to staff inductions were available and up to date. Staff supervision and team meetings were held on a regular basis and records we looked at confirmed this.

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?
We found that action had been taken to improve safety in relation to Regulation 20.

Care plans and risk assessments detailed people's individual needs and offered guidance to staff on how to best meet people's needs. Care plans and risk assessments were up to date.

Records of staff inductions were available and up to date.

Is the service effective?
We found that action had been taken to improve the effectiveness of the service in relation to Regulation 20.

Records demonstrated that staff were supported appropriately through recorded regular supervision, staff meetings and annual appraisals.

Care plans contained mental capacity assessments where appropriate.

Care plans and records were comprehensive and included people's nutritional and hydration needs.

Is the service caring?
We found that action had been taken to ensure records guided staff in person centred care in relation to Regulation 20.

Care plans demonstrated that care provided was person centred to individual's needs and information retained in them was correct and up to date.

Is the service responsive?
The accuracy of people's care records had improved in relation to Regulation 20.

Care plans and records were comprehensive and included Do Not Attempt Cardiopulmonary Resuscitation forms and recorded people's end of life care needs and wishes.

Rosecroft Residential Care 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 to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Rosecroft Residential Care Home on the 6 November 2014. This inspection was completed to check if improvements had been made to meet the legal requirements for one breach to regulation 20 we found after our comprehensive inspection on the 14 July 2014. We inspected the service against four of the five questions we ask about services. This is because the service was not meeting legal requirements in relation to these questions. This inspection has only considered the breach in Regulation 20.

The inspection was unannounced and undertaken by two inspectors. Before our inspection we reviewed information we held about the home which included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority commissioning team.

We looked at the care plans and records of four people living at the home and 13 staff supervision files and records. We spoke with the registered manager and two members of staff.

Is the service safe?

Our findings

At our inspection on 14 July 2014, we found that risks associated with people's care were not always assessed and appropriate plans were not always in place to reduce these risks. Records relating to staff inductions were not completed or available.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 10 October 2014.

We undertook this unannounced focused inspection on 6 November 2014 to check that the improvements required following our enforcement action had been implemented in relation to Regulation 20.

The registered manager showed us a new electronic care planning system which was introduced recently at the home. Each person using the service had a new care plan which was stored on an electronic system and copies of these were placed into paper files. They told us that they still used paper 'daily care plans' which recorded people's daily activities but advised this was soon to be introduced onto the electronic system. Care plans contained people's personal information including pictures, emergency contacts, assessments, care planning and risk assessments, monitoring, capacity and consent, medications and support guidelines related to people's specific health and social care needs.

The care plans and records were detailed, comprehensive and covered areas such nutrition and hydration, pressure sores, dementia care, diabetes, mobility, falls, personal care, capacity, risks, continence, night time care and medication.

There was detailed guidance in place for staff to follow on how to support people with their needs and how to manage possible risks minimising the risk of harm to them and others. For example a dementia care plan we saw documented particular risks and behaviours that may place the person or others at risk. These included walking or becoming disorientated or distressed. There was a detailed action plan in place guiding staff on how to support the person and how to respond to them in the event of these risks occurring. The person was also being assessed and supported by visiting health care professionals in relation to their mental health and behaviours and information recorded in their care plan assisted staff in managing their condition effectively. Their nutrition and hydration care plan made reference to these risks and included information about their health, wellbeing and preferences including the support they required at mealtimes. Their night time care plan also made reference to their mental health needs and included their preferred time to go to bed and how many pillows they liked. Hourly checks were undertaken to monitor the person and help ensure they were safe and well throughout the night.

Records of staff induction had been completed. The manager told us that most of the staffing team had worked at the home for six or more years and had completed an induction when they started work, however they did not retain the old induction records and these were not present in staff files. Following our last inspection the staffing team undertook a Skills for Care Induction programme. The manager showed us documentary evidence and training records confirming that all staff working at the home had completed an induction.

We found that the provider had addressed the breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Is the service effective?

Our findings

At our inspection on 14 July 2014 we found that staff were not always supported to deliver care that was safe and effective through regular supervision, appraisals and team meetings. People were not always protected from the risks of poor nutrition and hydration because records of nutritional needs were not up to date.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 10 October 2014.

We undertook an unannounced focused inspection on 6 November 2014 to check that the improvements required following our enforcement action had been made in relation to Regulation 20.

Records of staff supervision were now completed. Supervision records we looked at demonstrated that staff were provided with appropriate supervision on a regular basis in line with the provider's policy which states formal supervision will be provided every two months. Minutes from staff meetings held at the home confirmed that staff meeting were conducted in line with the provider's policy which details staff meetings are undertaken every two months. Recorded minutes from the 19 September meeting indicated that the registered manager and eight of the ten members of staff working at the home attended the meeting. Topics discussed included the new electronic care planning system, key working, effective communication, staff supervision and team work.

Care plans and records were detailed and covered people's nutritional and hydration needs. For example one person who had diabetes was at risk of poor nutrition. We noted that their new care plan provided staff with guidance on how to ensure the individual's specific nutritional needs were met. Risk assessments detailed the risks to this person and the support and actions staff were required to take in order to manage the person's diabetes and reduce the risk of health problems.

Care plans contained mental capacity assessments where appropriate and applications for Deprivation of Liberty Safeguards (DoLS) were considered in accordance with the Mental Capacity Act 2005 (MCA) where necessary to prevent harm. MCA records detailed outcomes of assessments and people's ability to make informed decisions independently about their care and treatment. People's consent in relation to their care and treatment was well documented and reference was also made to independent advocates and Lasting Power of Attorney's that were in place.

We found that the provider had addressed the breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Is the service caring?

Our findings

At our inspection on 14 July 2014 we found that people's care plans did not always demonstrate that the care provided was person centred to an individual's needs.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 10 October 2014.

We undertook an unannounced focused inspection on 6 November 2014 to check that the improvements required following our enforcement action had been made in relation to Regulation 20.

At our last inspection on 14 July 2014 we found that documentation contained in one person's care plan referred to and addressed the person by a different name. At that time staff were not able to explain the reason for this as the person was not referred to in any other way by this name. We looked at this persons care plan and records and confirmed that the person was referred to and addressed by their correct name. All documentation relating to this person was correct.

We found that the provider had addressed the breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Is the service responsive?

Our findings

At our inspection on 14 July 2014 we found that the service was not always responsive to people's end of life needs. Four people at the home had an advance care plan in place however none of the care plans contained a signed or authorised "Do Not Attempt Cardiopulmonary Resuscitation" (DNAR) form in place to ensure that their end of life wishes were respected.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 10 October 2014.

We undertook an unannounced focused inspection on 6 November 2014 to check that the improvements required following our enforcement action had been made in relation to Regulation 20.

Care plans and records belonging to people referred to at the last inspection were now detailed, comprehensive and included a completed DNAR form signed by their general practitioner. Care plans and records confirmed that people were involved in the planning of their end of life care needs and their wishes had been documented to ensure their wishes were respected.

We found that the provider had addressed the breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.