Countrywide Care Homes (2) Limited

Rose Lodge

Inspection report

Carers way
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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**

Overall summary

This inspection took place on 17 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting.

Rose Lodge provides care and accommodation for up to 54 people, including people living with dementia. On the day of our inspection there were 48 people using the service.

The home did not have a registered manager in place as the registered manager had recently left the service. 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. A new manager was in post and was in the process of registering with CQC at the time of our inspection.

Rose Lodge was last inspected by CQC on 17 April 2013 and was compliant.

Summary of findings

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff were aware of their responsibilities with regard to protecting vulnerable people and training records we looked at showed that staff were up to date with safeguarding training.

Training records were up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

We saw in the care records consent was obtained for sharing information, photography, agreement with care plan reviews and care plan participation. All of the records we saw had been signed apart from one, which was for a person who was recently admitted to the home.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the manager and looked at records. We found the provider was following the requirements in the DoLS.

People who used the service, and family members, were complimentary about the standard of care at Rose Lodge. They told us, “It’s lovely”, “she’s been here seven years and we couldn’t be happier” and “they are very caring”.

Staff talked to people in a polite and respectful manner, were responsive to people and interacted well and treated people with care and compassion.

Care records showed people’s needs were assessed before they moved into Rose Lodge and care plans were written in a person centred way.

We saw a copy of the provider’s complaints policy and procedure and saw that complaints were fully investigated and responded to.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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 safe.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service and the provider had an effective recruitment and selection procedure in place.

Staff were aware of their responsibilities with regard to protecting vulnerable people and training records we looked at showed that staff were up to date with safeguarding training.

Medication care plans were in place, were detailed and evaluated at least monthly.

Good

Is the service effective?
The service was effective.

Training records were up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

We saw in the care records consent was obtained for sharing information, photography, agreement with care plan reviews and care plan participation.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?
The service was caring.

People who used the service were clean and appropriately dressed.

Staff talked to people in a polite and respectful manner, were responsive to people and interacted well and treated people with care and compassion.

People had been involved in writing their care plans and their wishes were taken into consideration.

Good

Is the service responsive?
The service was responsive.

The home had a full programme of activities in place for people who used the service.

Care records showed people's needs were assessed before they moved into Rose Lodge and care plans were written in a person centred way.

We saw a copy of the provider's complaints policy and procedure and saw that complaints were fully investigated and responded to.

Good

Is the service well-led?
The service was well led.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Good

Summary of findings

People who used the service and their family members were asked their views on the quality of the service via annual surveys and regular meetings.

Staff told us they felt supported in their role and there was a nice atmosphere at the home.

Rose Lodge

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 17 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector and a specialist advisor in dementia took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff and district nurses. No concerns were raised by any of these professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people who used the service and seven family members and visitors. We also spoke with the manager and six members of staff.

We looked at the personal care or treatment records of seven people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at the home. They told us, “Oh yes, no concerns” and “I know she [relative] is safe”.

During our visit, we observed there were sufficient numbers of staff on duty. Call bells were answered promptly and if people required assistance we saw they were attended to in a timely manner. We discussed staffing levels with the manager, who explained that a dependency tool was used to calculate staffing levels and this was re-assessed every two months. The manager told us, and we saw from the rota, there were two senior care workers and six care workers on duty during the day and two senior care workers and three senior care workers on duty during the night for the 48 people who used the service. There was also an additional care worker rostered on duty between 8am and 2pm to assist during busy periods.

We asked people who used the service and visitors to the home whether there were plenty of staff on duty. They told us, “Yes, usually” and “yes, but could always do with more”. People were complimentary about the staff. They told us, “They’re lovely”, “very caring” and “[name] does a cracking job”.

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

The home is a two storey, detached building. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, warm, spacious and suitable for the people who used the service. People we spoke with were complimentary about the home. They told us, “It’s lovely” and “I can’t fault it”.

Both floors of the home comprised of a residential unit and a unit for people with a dementia type illness. The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. We saw window restrictors, which appeared to be in good condition, were fitted in the rooms we looked in.

The home had a large laundry room with separate entry and exit doors so that dirty laundry could be kept separate from clean laundry. We saw that clean laundry was kept on shelves, above floor level and in individual trays. The laundry area was clean and suitable handwashing facilities were available.

We looked at the safeguarding file and discussed safeguarding incidents with the manager, who was aware of her responsibility with regard to the recording and reporting of safeguarding incidents. We saw records of safeguarding incidents, including those reported to the police, and saw that CQC had been notified of all the incidents. Staff we spoke with were aware of their responsibilities with regard to protecting vulnerable people and training records we looked at showed that staff were up to date with safeguarding training.

We saw the home’s accidents and injuries file, which included a record of accidents and injuries by month. We also saw the reports for each accident and injury, which included who had the accident/injury, what was the cause, what action was taken and the signature of the staff member who recorded it.

We saw that medicines were stored in secure trolleys and controlled drugs were stored in a secure, wall mounted cabinet. The keys to the trolleys and cabinet were held by the senior care workers. We saw that medication care plans were in place, were detailed and evaluated at least monthly. The care plans included evidence that the needs of the person had been considered when the care plan had been written. For example, “[name] is aware of the importance of all medications prescribed” and “[name] has capacity to refuse all medications”. The plan also described how the person was to take their medicines, including PRN (when required) medicines such as paracetemol. We spoke with a senior staff member about medication, who was knowledgeable and aware of the use of sedatives if a person was agitated and the use of paracetemol for pain relief.

Good

Is the service effective?

Our findings

People who lived at Rose Lodge received effective care and support from well trained and well supported staff.

We looked at the training records for four members of staff and saw certificates, which showed that training was up to date. Training included safeguarding, manual handling, mental capacity, infection prevention and control, health and safety, food safety, fire awareness, first aid and dementia. The registered manager showed us the electronic training matrix, which was colour coded to show when training was due and also if training was overdue. We also saw that staff had completed an induction programme for a period of three months when they began working for the service. This included an introduction to the home, company policies and procedures, e-learning and shadowing members of staff in the different aspects of the role.

We looked in the staff files to see whether regular supervisions and appraisals had taken place. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We discussed supervisions with the manager, who told us that staff supervisions take place six times per year. We checked four members of staff's records and saw supervisions had been carried out regularly. Supervision records also included evidence that competency assessments had taken place such as personal hygiene and appearance and medication. We also saw copies of appraisals for those members of staff who had been working for the service for at least one year. This meant that staff were properly supported to provide care to people who used the service.

We looked at seven care records during our visit and saw that people and their family members had been asked to provide consent to their care and treatment. Consent records included consent to care and share information, consent to photographs and agreement with care plan reviews. The person who used the service or their family member had also signed care plan participation forms to say they had been offered the opportunity to be involved in the planning of their care and had read their care plans and risk assessments. All of the records we saw had been signed apart from one, which was for a person who was recently admitted to the home. We asked people and family members whether they had been asked to provide consent to care and treatment. They told us, "Yes, I signed the forms" and "they speak to me when I'm here and they ring me at home if they need anything else".

We also saw copies of communication records in care plans, which recorded when family members had been contacted to let them know of any changes or appointments, for example, "Spoke to [name]'s family to let them know that [name] has been seen by the GP today."

The care records we looked at included 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. All of these were up to date and showed who had been involved in the decision making process, for example, the person who used the service and family members.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, social workers, physiotherapist, optician, dentist and chiropodist.

During our visit, we observed lunch in the ground floor residential unit and in the first floor dementia unit. We saw staff supporting people to be independent but assistance was offered and given if required. We saw one person in the dementia unit become agitated at lunch time and we observed staff deal with the situation in an appropriate manner and calm the person down. We also saw that people could eat in their own rooms if they preferred. We asked people who used the service and their family members what the food was like. They told us, "She loves the food", "the food is very good". We talked with kitchen staff, who demonstrated that they understood people's individual needs. For example, one person who used the service had a nut allergy. Kitchen staff had followed Food Standards Agency guidance and we saw that food and containers in the kitchen were clearly labelled with their contents.

We saw copies of nutritional assessments in the care records, which were evaluated on a monthly basis. We also saw that weight records and malnutrition universal scoring tools (MUST) were up to date and regularly reviewed.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are

Good

Is the service effective?

looked after in a way that does not inappropriately restrict their freedom. We discussed the Mental Capacity Act and DoLS with the manager, who was aware of the requirements and where people lacked capacity, we saw capacity assessments had been carried out and best interest decision forms had been completed. The manager had discussed DoLS with the local authority and had followed their guidance by prioritising which people who used the service required a DoLS application. At the time of our inspection, one DoLS application had been authorised by the local authority. This meant the provider was following the requirements in the DoLS.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. We looked at the design of the dementia units and saw that to aid orientation, people's bedroom doors were painted in different colours, were clearly numbered and some had photographs and personal information on the wall next to their bedroom door. We saw that bathroom and toilet doors were appropriately signed and clearly identifiable. Corridors were clear from obstructions and well lit. Items to touch were fixed to the walls and handrails were secure and painted a different colour to the walls. All of this helped to aid people's orientation around the home.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Rose Lodge. They told us, “It’s lovely”, “she’s been here seven years and we couldn’t be happier” and “they are very caring”.

People we saw were clean and appropriately dressed. We saw staff talking to people in a polite and respectful manner, were responsive to people and interacted well and treated people with care and compassion, for example, asking people if they required assistance while mobilising around the home and assisting them in a calm and re-assuring manner.

We saw small kitchen areas were provided for people to use. Staff told us that people were encouraged to use these facilities. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

We looked at the care records of seven people who used the service. We saw that care plans were in place and included falls, nutrition, communication, risk to skin integrity, personal hygiene, manual handling, pain, continence management, end of life and medication. The care plans described in detail the abilities of the person, areas of dependence, the desired outcome of the care plan and actions to be taken.

Each care plan contained evidence that people had been involved in writing the plan and their wishes were taken into consideration, for example, we saw the care records included a section where the person could say what name they preferred to be called. We also saw that end of life wishes, including funeral arrangements, had been discussed and documented in end of life care plans. For example, one person’s end of life wishes included “To be treated with dignity and respect”, “she wishes to be cremated”, “being pain free is important to [name]” and “[name] is very important to [name]”.

We saw that the care records in the first floor dementia unit were stored in cabinets which were not locked and some observation charts were on display in the dining room, which anyone had access to. This meant that confidential information was not kept secure. We brought this to the attention of the manager who agreed to secure the documentation.

We saw copies of daily reports, which were up to date records and included at least two signed and dated entries per day. These included evidence of promoting independence and personal choice, for example, “[name] had a lie in this morning”, “[name] liked to spend time in her own room” and “[name] likes to see to all her own personal care”.

We saw there were many visitors to the home during our visit. A coffee shop was located inside the home, near to the main entrance. People who used the service could spend time in the coffee shop with their family and visitors.

We saw advocacy services were advertised on the notice board in the ground floor foyer area, alongside a dignity challenge poster provided by dignity in care. This meant that information was made available to people who used the service and visitors should they require it.

We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, “Definitely” and “they look after them as if it’s their own family member”. One visitor was very complimentary about the care provided to their family member at the home. She told us, “They check her every couple of hours. They know how to communicate with her and they know her needs. I go on holiday a lot and I don’t have any concerns leaving her.” This meant that staff treated people with dignity and respect.

Good

Is the service responsive?

Our findings

We saw that care records were regularly reviewed and evaluated.

We looked at the care records of seven people who used the service. These had been written in consultation with the person and their family members and described the person's wishes. For example, what was important to them, their daily routine preferences, specific personal wishes, activities and outcomes. All the care records we saw were regularly reviewed and included consultation with healthcare specialists.

We saw that assessments of the person had been carried out pior to admission and again during the admission process. These included assessments of the person's communication needs, current state of health, eating and drinking needs, mobility and how to maintain a safe environment for them. For example, the mobility and safe environment assessment for one person described how they were fully mobile with the use of a walking aid.

The care plans described in detail the abilities of the person, their areas of dependence, the desired outcome of the care plan and actions to be taken. For example, one person had a recent increase in falls and required increased supervision from care staff. The desired outcome of the care plan was for the person to remain independently mobile whilst reducing the risk of falls. An action plan was in place and included updating the risk assessment at least once per month. We looked at a copy of the risk assessment and saw that it had been reviewed monthly since the initial increase in falls was recorded. This meant that care records were regularly reviewed and kept up to date.

We saw the activities board in the main foyer, which included games, beauty treatments and exercise sessions. During our inspection a hairdresser was visiting the home. During the afternoon a singer attended the home and people were encouraged to join in with the singing. We saw people who used the service and staff members dancing, clapping and joining in with the singing. We asked people who used the service, family members and visitors if there were enough activities do at the home. They told us, "There's always something going on", "we enjoy ourselves", "there's lots to do" and "there are some real characters here, they have fun".

We saw a copy of the provider's complaints policy and procedure. The complaints procedure was on display on the notice board in the foyer alongside the whistleblowing policy and ombudsman contact details. We looked at the complaints file and saw there had been five complaints in the last 12 months. Each of these records included copies of complaint report forms, letters from complainants and letters sent in response acknowledging the complaint and providing the outcome. All of the complaints we looked at had been appropriately dealt with. This meant that comments and complaints were listened to and acted on effectively.

People who used the service and their family members we spoke with were aware of the complaints policy but had never made a complaint. We asked them if they knew how to make a complaint and what they would do. They told us, "No complaints, but I would speak to the manager" and "yes, I know how to make a complaint but I haven't got any".

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home did not have a registered manager in place as the registered manager had recently left the service. A registered manager is a person who has registered with CQC to manage the service. A new manager was in post and was in the process of registering with CQC at the time of our inspection visit.

People who used the service, and their family members, told us they were happy with the care and management at Rose Lodge. One family member told us, “Never had any problems with the manager or the staff”.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw records of the provider’s monthly visits. These included discussions with people who used the service, relatives, visitors and members of staff, a check of the premises, complaints, records and whether actions from the previous visit had been completed. These visits were also informed by the regular audits that were carried out by the manager and staff within the home, including audits of care records, health and safety and premises. We saw copies of the most recent audits. All were up to date and included action plans for any identified issues.

We saw that maintenance and servicing records for the home were up to date. These included, hot water temperature checks, gas servicing, lift and equipment servicing, five year electrical installation check, fire alarm and fire protection equipment servicing and checks, emergency lighting, call bells, window restrictors and portable appliance testing (PAT).

We saw minutes of care staff meetings, kitchen meetings and health and safety meetings. These meetings took place regularly and staff meetings included discussions regarding recruitment, supervisions, maintenance, cleaning and activities.

Staff told us they felt supported in their role and there was a nice atmosphere at the home. One member of staff told us, “All the staff have been here a long time, which tells you something” and “they made me feel very welcome”.

We saw the minutes of the most recent residents’ and family meeting, which had taken place on 11 December 2014. Subjects discussed at the meeting included menus, staffing, activities, laundry, the premises and communication. We saw from the minutes that where issues had been raised, the manager had provided an explanation, for example, relatives had suggested getting patio doors fitted to the residential dining room so that people could access the outside patio area. The manager agreed to raise this at her next meeting with the board of directors. The manager told us these meetings took place every two months.

We saw an annual customer satisfaction survey took place and saw the results from July 2014. The survey asked people who used the service, and their family members, questions about the quality of the service provided at Rose Lodge. We saw these results were made available to people who used the service, family members and visitors and included actions taken. These included speaking individually with people who had requested a follow up, made minutes of meetings available in the home and followed up on progress with staff at staff meetings.

This meant that the provider gathered information about the quality of their service from a variety of sources.

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.

This section is primarily information for the provider

Enforcement actions

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