Barchester Healthcare Homes Limited

Rothsay Grange

Inspection report

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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

Rothsay Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

There was a registered manager in post. A registered manager 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.

Rothsay Grange provides care and accommodation for up to 60 people who have dementia and / or health conditions. When we inspected there were 34 people living in the home.

The home was purpose built, spacious and equipped to meet the needs of people living there. There were extensive grounds that could be accessed by some people to the front of the premises and a large courtyard garden accessible to all residents.

At the last inspection of this service on 31 March and 1 April 2017 we rated the service as 'Requires Improvement'. This was due to there still being insufficient staffing deployed to meet the needs of people living in the home and improvements needed in quality audits and responses to complaints. We found at this inspection that improvements had been made in all previous areas of concern and the service had achieved an overall rating of 'Good'.

There were systems in place to keep people safe and staff had completed training in safeguarding.

A robust recruitment process ensured that only people suitable and qualified to work in a caring role were employed at the service.

Medicines were safely managed. Nurses administering medicines were protected from interruptions during the medicines round.

Staff asked for consent before providing care and understood the Mental Capacity Act (2005) and supported people with decisions if they lacked capacity to make them independently.

Appropriate applications were made to the local authority to deprive people of their liberty.

People were supported with their nutrition and hydration needs, referrals to appropriate healthcare professionals were made and care plans developed to prevent malnutrition.

Staff enabled people to maintain their dignity and provided respectful and empathetic care.

Care plans were person-centred and involved people and their families. These were regularly reviewed and updated according to the changing needs of individuals. Peoples personal histories were in depth and contained contacts for important friends and relatives.

Care was also person-centred. Some people liked staff to be informal and jocular when supporting them, others liked a more formal approach. Staff ensured they addressed people by their preferred name and took the approach requested by them.

End of life care plans were holistic and included details of people's spiritual needs.

The registered manager and provider completed regular audits to ensure the service was providing safe and good quality care. If there were areas requiring improvement the registered manager worked with the staff team to make improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Sufficient staff were deployed to meet people's needs.

Medicines were safely managed.

Premises maintenance checks were methodical and thorough.

Is the service effective?

Good

The service was effective.

Staff participated in regular and effective supervisions.

Thorough pre-admission assessments ensured that people's needs could be met in the home.

The premises were fully accessible and suitable for purpose.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

People were dressed in clothing of their choice and looked cared for.

People were treated with dignity and respect at all times.

Is the service responsive?

Good

The service was responsive.

Peoples care plans were reviewed regularly and relevant people were consulted.

End of life care plans were holistic and detailed.

People receiving end of life care and their relatives were supported in a holistic way

Is the service well-led?

Good

The service was well led

The service had developed extensive community links.

Regular audits picked up concerns and they were addressed in a timely way.

Positive feedback was received about the management team and how they ran the home.

Rothsay Grange

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 5 and 6 June 2018 and was unannounced. The inspection team consisted of one inspector, one specialist advisor who was a nurse and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both experts by experience had knowledge of using regulated services and caring for people with dementia.

Before we inspected we reviewed all information we already had about Rothsay Grange. We looked at previous inspections and feedback from health and social care professionals and notifications. A notification tells us information about important events in the service that the registered manager is required to inform us about.

We reviewed the Provider Information Return (PIR). This is information supplied to us by the service annually which provides key information about what they do well and any forthcoming improvements. The PIR was completed more than a year before this inspection so we checked to ensure this information was still current.

During this inspection we spoke with 30 people living in the home, 10 relatives, 15 staff members and the registered manager. We pathway tracked five people and looked at the records of three others. We checked recruitment files for eight staff.

We looked at health and safety information and information about the premises and equipment such as service records and water hygiene records and checked audits, policies and procedures.

We last inspected this service on 31 March and 1 April 2017 and found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

Good

Is the service safe?

Our findings

People living in the home and their relatives told us they thought the home was a safe place to live. One person said, "Oh, yes, extremely. I would not be anywhere better". A relative told us, "Oh, yes, my mother feels very safe here. She has been here for three years". Another relative said when asked if they thought the service was safe, "Safe, yes I do. My (relative) is mobile and at risk if the environment is not secure. There are call buttons, codes on doors and windows only partly open".

When we inspected in March 2017 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing. There had, at times, been insufficient staff members deployed to meet the basic care requirements of people and to support them to engage in meaningful activities.

At this inspection we observed that sufficient staff were now being deployed and the legal requirements were being met. We checked staff rotas and staffing requirements and there were, according to the calculated dependency levels, sufficient staff available throughout the day. We did not note call bells ringing for excessive amounts of time before being answered and saw staff taking time to interact with people outside of performing basic care duties. People told us that though their bells were not always answered immediately the wait was not too long. One person told us, "Yes, I have a call bell, they are not too bad for answering", another said, "I have a call bell. The girls come straight away". A staff member told us they would usually manage to answer call bells in one or two minutes however this would be longer if they were supporting someone already. There were staff available during mealtimes to support people both in the dining rooms and in people's own rooms.

Staff members were aware of the requirements of the safeguarding policy and procedures and when asked told us that they would speak to the nurse, senior carer or a member of the management team if they had concerns for someone's welfare. They had an awareness of different kinds of abuse and the signs and symptoms that would cause them concern. The provider had a log of all safeguarding alerts, which agencies they were reported to and the actions taken in response including meeting minutes and in-depth investigations as needed.

Care files were comprehensive and reflected the assessed needs of each individual. Risks were assessed for a wide range of different hazards including falls, use of the call bell, choking, use of bed rails, mobility and tissue viability. Other safety information about people was also available including definitions of, and information about, specific health conditions, particularly if uncommon.

We saw in depth risk assessments concerning the premises, equipment and maintenance work being undertaken at the home. There were risk assessments for radiators, hot water, lack of hot water, the passenger lift, catering and domestic kitchen equipment. The range was broad and consideration was taken not only for when items were working but if there were breakdowns or malfunctions, the maintenance team had considered the risks when replacing a tap, repairing a shower or decorating the premises.

Regular safety checks and services were carried out on equipment in the home. Reports concerning the condition of each item and any necessary works were retained and annotated to indicate when works had been completed. People were protected from the risk associated with legionella by vigilant checks on water temperatures, flushing of infrequently used outlets and regular water sampling to detect legionella. The last samples taken showed no concerns. The provider had also installed baths that flushed automatically to reduce the risk of legionella spores developing.

Recruitment practice was safe. Prospective staff members completed an application form, supplied a full employment history and two employment references as well as having a check completed with the Disclosure and Barring Service (DBS). The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that people employed at the service are suitable to work there. The provider had also checked that nurses employed were registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practice in the UK must be on the NMC register.

Medicines were managed safely. There had been some concerns regarding medicines noted by management at Rothsay Grange however the registered manager had been proactive and had an external audit of the medicines completed. This had highlighted where medicines management needed to improve and actions had been taken to address this. An additional audit completed by the supplying pharmacy the month before our inspection had found the service to be fully compliant with medicines. In addition to external audits, the deputy manager completed a medicines audit monthly and controlled drugs were audited on a weekly basis. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation (and subsequent amendments), which are closely monitored and stored in secured cabinets.

Medicines were only administered by a nurse or care practitioner, or a senior care assistant who had undertaken additional training. They wore a red tabard to warn people not to disturb them during the medicines round. Medicines were stored safely. When unattended, medicines trolleys were locked and when not in use they were stored in the locked clinical room.

The temperature of the clinical room and the medicines fridge were taken at least daily and monitored and when we inspected, both were within a safe range to ensure the efficacy of the medicines. Sharps bins were kept in the same room along with a locked cabinet for homely remedies. A homely remedy is another name for a non-prescription medicine that is available over the counter in pharmacies and is used to treat everyday conditions such as a headache or a cold. We also saw that a medicines manual, good practice guidance and the providers policies were all available to staff in the clinical room. We checked medicine administration sheets (MAR). These showed that medicines were being administered as prescribed and were being checked and signed as required.

The home was very clean, there were no offensive odours at any time during our inspection and staff were observed wearing suitable personal protective equipment (PPE) for tasks. Gloves and aprons were used for personal care tasks, tabards worn over uniforms when serving meals and staff were noted to use anti-bacterial hand gel in addition to washing their hands before undertaking tasks. We spoke with housekeeping staff who were aware of the importance of cleanliness in preventing infection.

The provider maintained a log of accidents and incidents and reviewed this to look for possible patterns and causes. These were discussed at a monthly clinical meeting. Dangerous occurrences would trigger a review and update of relevant risk assessments and this learning was passed to staff. For example, the medicines audit was requested following medicines errors. The registered manager sought assistance from an outside agency who enabled them to learn from the situation.

Good

Is the service effective?

Our findings

Staff participated in regular supervision meetings and told us they were effective and of benefit to them. At the time of our inspection there was a completion rate of 93% for both supervisions and annual appraisals for staff members. One staff member told us that their supervision offered them "a chance to update myself, it's really useful".

Staff also participated in training courses to enable them to be suitably skilled and knowledgeable. Courses attended by staff included food safety, fire safety, infection control, moving and handling and safeguarding including the Mental Capacity Act 2005 and Deprivation of Liberties Safeguarding. Training courses had a completion rate of between 81% and 100%.

People were supported to maintain a healthy diet and weight. People were weighed monthly and weights were recorded and assessed using a nationally recognised tool. If the tool indicated they were at risk of malnutrition, meals were fortified as required and additional snacks and prescribed build-up drinks were given.

Meals and drinks were prepared to the taste of each person as much as possible and if someone did not want the meals offered then alternatives were provided. We saw people choosing their meal at lunchtime and there was a menu available in the dining area at all times with the whole days menu. We did note that this was written in a standard typed format and could be made more accessible for people with visual impairments or cognitive problems. Meals looked and smelled appetising and people told us they were generally good, varied and tasty.

Lunchtime was a very social occasion. On one floor, a person arrived late for their meal. Staff and other people greeted them and welcomed them to their table. They were given a choice of all menu items and three different fruit juices. Staff reminded them not to have the cranberry showing an awareness of their health needs. During lunchtime a relative arrived for a visit and they were immediately offered a drink and some lunch.

Feedback about food was almost all positive with compliments about the quality, the range of choices and portion sizes. One relative told us, "The food for my (relative) is pureed. It always comes up. Never a problem. My (relative) has never eaten as well as now. Has put on weight. Good quality food". People also told us, "Yeah, [the food] very good. Very good choice. If it's something you don't like there is always something else", and "It amazes me that menus always have 3 options, good variety. They check the temperature of the meal."

Before being moving into the care home, people were assessed to ensure that the service could meet their needs and wishes. The assessment included information about people's basic needs including allergies, medicines, chewing and swallowing, nutritional needs and their likes and dislikes. Once the person moved into the home this was built upon to create detailed care plans. In addition to health focussed needs, the service assessed peoples emotional, spiritual and cultural needs, explored the person's interests and

discussed their needs and preferences about personal care. There was evidence in the care plans that the person had been involved in the process however if someone was too unwell or lacked the capacity to be involved wherever possible the service had involved relevant others such as family or close friends.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

Care files contained assessments of capacity and best interest decisions as needed. Staff understood the principles of the Mental Capacity Act 2005, when asked they told us they would assume someone had capacity unless assessed otherwise.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications for a DoLS has been submitted or were awaiting reassessment as they had expired.

Staff were aware of the importance of protecting people from harm and security measures such as key-pad locks on the 'Memory Lane' floor were in place and utilised by staff.

Staff sought people's consent when they were providing care. One person told us "Yes, they ask my permission", another said, "My family has Power of Attorney". A relative said, "They always get permission to care. My (relative) is involved. Any change they talk to me about it. Yes, I am involved in best interest decisions. DOLs recently". Where appropriate, staff involved family members in best interest decisions and reviews. A relative told us, "The care plans are reviewed every six months. We go through them thoroughly and they are signed. For things like flue jabs I sign a consent form. They engage us".

Healthcare professionals attended the service regularly. GP's visited and specialist healthcare professionals such as the tissue viability nurse (TVN), dentist, podiatrist and optician visited as needed. The TVN received emailed referrals from the home with photographs of pressure ulcers, assessed them and supplied a wound care plan for staff to follow. Staff recognised if people were unwell and acted in response. A person living in the home told us "Yes, they pick up quick if I'm not feeling well. The doctor came Monday and put me on tablets for swollen feet. They immediately send for the doctor if you're not feeling well".

The environment was suitable for people. People that needed a more safe and secure environment could have this need met while other people commented that they enjoyed the freedoms offered by the front door being unlocked for them to come and go as they pleased. Corridors were wide and the communal lounge and dining areas were large and suitable for people using mobility aids such as walking frames and wheelchairs to access freely. A large grassed area and summer house could be accessed by people who had reasonably good mobility and a large courtyard garden was accessible and in use for activities.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. A relative said, "They are very kind, caring and compassionate. They treat (person) in a special way. (Person) is posh. The staff accommodate this and treat (person) well. They say your (person) is just like the queen, they love (person). They are very kind and joke and tease which (person) loves." A person living in the home told us, "They're good to me, very kind".

The service was proactive in meeting the spiritual needs of people living in the service. Each month three different denominations of minister attended the home to provide services to people. Peoples care files also reflected their spiritual needs along with their cultural and social needs.

We saw staff members supporting people with mobility, care and at mealtimes. We saw that staff were keen to maintain people's skills and abilities and if they could complete a task, they were gently encouraged to do so. If people were reluctant to participate in activities staff would gently coax them to try the activity to ensure they were occupied.

Care files included information about people's lives before coming to live at the home and about the things that were important to them. Contact details were held for family members, even those who they were no longer in contact with, in case the person decided they wanted to make contact later and were unable supply names and addresses due their dementia having progressed for example. Current and past interests were also recorded. Visitors were welcomed and this supported them to maintain relationships with people. One person told us, 'Yes, they (visitors) are most welcome. My niece sent me a card saying how welcomed she felt. Oh, yes, they produce coffee, tea and everything.'

Staff cared for people in way that was mindful of their dignity. A person living in the home told us, "Yes, they seem to be kind and caring. They treat me with respect. They're very careful with my dignity. They take three towels when I have my bath to keep me covered". A relative told us, "The current staff are all caring. They close doors and curtains and put a notice on the door to say care is being given to show respect and keep dignity." We asked staff how they would support someone to maintain their dignity and they told us they would speak to them, keep them covered as much as possible during care, knock at doors to respect their privacy and address them by their preferred name.

We saw that staff were informal with some people and more formal with others as per the persons preferences and a relative told us they liked how there was informal joking and 'banter' with their family member. They were younger than many of the people in the home and enjoyed staff members laughing with them and treating them informally.

We saw staff supporting people who had become distressed. They distracted them and offered them a cup of tea and sat with them until they became calm. Staff responded quickly and with empathy when someone needed support with care. There was warmth and a friendly approach seen from staff throughout our inspection.

Care had been taken with people's appearances. People were dressed in clothes that were clean and pressed and appropriate and their hair had been brushed. Staff took time with people to chat and offer them reassurances. We saw staff who had in depth knowledge of people caring for them in an empathetic way. Staff could tell us about people's lives before coming to the home and used this knowledge to start conversations and help to settle those who were distressed.

Good

Is the service responsive?

Our findings

Care plans were specific to individuals and when a person had complex needs included careful detail as to the care delivery. One person who had complex needs received much of their care in bed and told us that staff supported them well. This included all care tasks as well as ensuring that an air mattress was correctly set up and repositioning the person regularly. This person used a tablet device to communicate. A relative told us there had been times when communication was not easy as there was frequent use of agency staff members who were not familiar with the person's needs. They told us this had now improved and staff who were not familiar with the person did not provide support without an experienced staff member present.

A 'resident of the day' programme meant that a person had their care file reviewed and met with their allocated nurse, the chef and the activities officer to ensure they were receiving their care as they wanted it and to find out if there was unmet need.

The provider was working toward meeting the accessible information standard (AIS). The AIS requires the service to identify, record, flag up to staff, share with relevant others and meet the information and communication needs of people, Information was presented in different ways depending on the person it was aimed at. In the 'Memory Lane' area, activities were represented by pictures with words. In all areas of the service there was a photographic staff board identifying to people who would be providing care that day. Menus were produced on text format and not accessible to all residents, staff supported people by reading out the menu however it may be useful to consider more accessible formats.

The service had a complaints policy and procedure and people told us that if they had a concern they felt able to mention it to staff. One person said, "I would complain, but I have never done it. I would speak to [registered manager]". A relative told us, "If you see the manager at the time, the manager diffuses and takes action straight away". Before our inspection we had spoken to a relative about a complaint they had made about the service. We asked the registered manager about the complaint and if it had been resolved. We were told that the matter had been escalated and was being dealt with at head office as per the complaints procedure. A log was kept of complaints and once investigations of complaints were completed, learning was shared with team members through staff meetings and supervision.

People and their relatives had contributed to end of life care plans called 'Hopes and Concerns for the Future' which were held in care files. Some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms completed and signed by healthcare professionals. These had either been completed with them or if they lacked the capacity to do so, on their behalf by the medical professional.

The end of life plan was holistic and looked at all areas of a person's needs and wishes as they reached the end of their life. Areas covered included where they wanted their care to be provided in their final days and who they might want to be with them and any faith requirements. Other information such as people's life stories was used to supplement these plans, their favourite music, foods and memories were of use to those providing support to people.

Once a person had been assessed as requiring end of life care, staff liaised with other healthcare professionals to ensure they were kept comfortable, pain and symptom free. At the end of life when the care plan was in use, nursing staff and healthcare professionals such as the GP, Macmillan support, Hospice Teams and Palliative Care Teams liaised to arrange for the use of anticipatory medicines to minimise pain, nausea and distress for the person. These medicines were arranged by the GP and were readily available for the person as they need them. The service ensured that relatives were kept fully informed and the End of Life and Palliative Care Policy is specific that staff did not collude to conceal information about the person from them or their relatives.

Relatives were offered support during the end of life stages and were encouraged to visit often and at any time. The service provided family members with refreshments and access to bathing facilities if they were visiting for extended periods and supported them emotionally during and after death had occurred. Relatives could remain with the person as long as they wished after their death.

Monthly resident's meetings were held and chaired by a person living at the service. The meetings were open to all residents however were not well attended. The chair of the meeting told us that there was a standing agenda and residents could raise items of concern. Staff such as the chef, the maintenance manager and the registered manager had also attended so they could deal with concerns as they arose. We saw the minutes of the last three resident's meetings. People had raised matters that were important to them and had them immediately addressed by staff with the relevant expertise. The meetings enabled people living in the home to have their views heard.

There were activities each morning and afternoon. We saw a gardening activity in the courtyard garden. People were encouraged to participate in planting flowers but if they preferred they could just watch. Some people were there for the company rather than the activity. A second activities officer had been recruited and having worked in 'Memory Lane' would focus on developing the activities for those who were living with dementia.

Good

Is the service well-led?

Our findings

A new registered manager was in post at the service and had worked hard, since the last inspection to drive improvements and develop the service. People told us they knew who she was and they spoke to her when she was out in the care home. People told us that they had several changes to the registered manager but that the current manager was a positive change for the service. The provider ensured the registered manager was appropriately supported and provided opportunities for continuing professional development.

There was a clear route for communication in the service. There were handovers at the start of shifts, these were verbal as well as in the form of a written handover sheet. Nurses and care practitioners maintained diaries as handover records with their colleagues. One staff member told us that the diaries had reduced the possibility of miscommunication about people's care.

Staff had monthly team meetings and there were clinical governance meetings monthly with nursing and management staff to ensure peoples care was being appropriately delivered. Residents and relative's meetings took place and were an opportunity for people to raise concerns and the registered manager to respond.

The service had developed extensive community links. The Customer Relations Manager for the provider told us of several initiatives the home had set up that benefitted the community. 'Don't dine alone' invited older people living in the community who might be lonely to the home once per month for a meal and some company and a chance to join in afternoon activities. 'Armchair Zumba' was held every other week and was open to members of the public as well as people living in the home. The service had hosted a young carers evening, rewarding local young carers with a certificate and a gift to recognise their hard work.

We attended a monthly professionals networking breakfast during our inspection. There was a mix of other care service managers and healthcare professionals. These sessions were open to all who worked in the field of health and care and provided an opportunity for people to link and share skills and knowledge.

Future events included a hearing awareness day offering a hearing and wax assessment for people at the home and living locally. The service also opened to emergency service personnel. Staff had frequently seen paramedics taking their breaks in layby's and car parks and invited them to take breaks in the warmth and comfort of the home where there were facilities that could be used as well as drinks and cakes on offer.

The registered manager completed monthly audits of areas such as medicines, skin integrity, staff supervision and training. These gave up to date information about areas that needed improvement or which were particularly effective. The provider commissioned annual quality assurance questionnaires which were distributed to people living in the home and their families by an external market researcher. Results of these were collated and sent in report form to the manager who acted on areas that needed improvement.

We received positive feedback from staff members about both the registered manager and the deputy

manager. We were told they were supportive, receptive to ideas and encouraged development within the teams. If staff were rushed or someone needed support, they would not hesitate to step in and support with care or assist at lunchtime. A staff member told us, 'Without a doubt, now is the best it has ever been…I would definitely place my family here'.