The Michael Batt Charitable Trust

Rushymead Residential Care Home

Inspection report

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Date of inspection visit: 31 July 2014 and 01 August 2014
Date of publication: 09/01/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this unannounced 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Rushymead Residential Care Home provides accommodation and care for up to 28 older people, some of whom may live with dementia. At the time of our visits there were 23 people living in the service. Rushymead was previously a private country house which has been adapted for use as a residential care home. It is set within extensive grounds with views over the adjoining countryside.

Summary of findings

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People who lived in Rushymead, their relatives and health and social care professionals involved with them were very positive about the standard of care they received or observed. They said staff were very caring and capable. Most of them thought there were sufficient staff numbers to meet their care needs effectively. One person told us they had sometimes experienced a delay in response to their call bell at night. Other people told us this had not been an issue for them.

Staffing levels had recently been increased at key times, for example during the early morning to help get people up and ready for the day. Staff said this had been a significant improvement for them and the people they provided care and support for. An additional activity organiser had been appointed with specific responsibility to provide social stimulation for people living with dementia.

Whilst people told us they felt safe we found there were some environmental risks to their safety which had not been addressed or had not been dealt with promptly. For example, there were some potential trip hazards within the home and externally in the garden. We also found in one case the recruitment process had not been fully completed before the person started work. Recruitment records did not show how any potential risk, arising from a Disclosure and Barring Service check had been assessed to make sure the applicant was suitable, although we were told this had been done.

Staff had received appropriate training to enable them to provide safe and effective care to the people they support. Staff training was monitored and meant people could be confident their care was provided by staff that had the necessary skills and training.

People were supported to stay healthy, including eating and drinking enough. Care plans had recently been revised in order to make them easier to use and more effective. People were involved in decisions about their care where possible. There were regular reviews of people's needs and associated risks to their health and safety. Where these had changed, appropriate action was taken and care records were updated. Where people did not have the capacity to make certain decisions about their care, there was an appropriate, robust process in place. This was being followed to ensure any decisions made were in their best interest. Staff were trained to identify signs of abuse and knew how to report it.

Although there were no regular meetings of people or their relatives, reviews of care involved them and they said they felt free to raise any issues or concerns they had directly with the registered manager or staff.

There was a formal complaints process in place, and people were asked for their views of the service through regular surveys. Any issues arising from these were noted and where possible, action taken to address them.

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?

Requires Improvement

The service was not consistently safe. Although people who used the service and their relatives said they felt safe, there were environmental hazards that had not been dealt. In addition to this in one case the recruitment process for staff had not been followed in line with the provider's own policy.

Staff had received training in safeguarding adults and knew what to do if abuse was seen or suspected. Staff understood the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. People's human rights were recognised, respected and promoted and this was supported through staff training. Where people did not have capacity to make informed decisions for themselves, the service ensured decisions were taken and recorded in a way that ensured people's best interests were protected.

People's care records included the information staff required to meet their assessed care needs. Care records were reviewed and kept up to date. Potential risks to people's health, safety and welfare were identified and either eliminated or managed.

Is the service effective?

Good

The service was effective. People received care and support from sufficient numbers of appropriately trained and supported staff. People's health and care needs were assessed and monitored. People were encouraged and supported to make sure they had enough to eat and drink. They had access to the community health services they required to maintain their health and welfare.

People had the opportunity to take part in activities in the home. They were able to express their views about their care and to make decisions for themselves where they were capable of doing so. They were able to exercise choice about what they did and how they spent their time.

Staff had a good understanding of the people they supported. There were care records in place to provide information about people's needs and how they were to be met in the way the person wanted them to be.

Is the service caring?

Good

The service was caring. We received very positive feedback about the standard of care provided from people who received care, their relatives and health and social care professionals who were involved with them.

We observed staff treated people with respect and with due attention to their dignity, for example when providing personal care.

Summary of findings

The values of the service were reflected in the relaxed, friendly and informal atmosphere within it. People commented favourably about the 'homely' feel of the service.

Is the service responsive?

Good

The service was responsive. People were involved in making decisions about their life. They were helped to make informed choices and were guided not directed by staff.

People said they knew how to make a complaint if they needed to. They also said they were more likely to raise any concerns they had informally with the carers or the registered manager.

People were given the opportunity to take part in activities within the home on a daily basis and less frequently outside of the home in the community. To reflect the increased number of people in Rushymead living with dementia, the service had appointed a dementia champion and an additional activities organiser who focussed on the provision of activities for them.

Is the service well-led?

Good

The service was well-led. People commented favourably about the way the service was managed and the teamwork of all of the staff. People who lived in Rushymead, their relatives and people associated with their health care were positive about the way the service communicated with them and responded to any issues they raised.

The service was subject to routine audits, for example medicines management and the provider made frequent visits where key functions of the service were assessed and monitored. Improvement and action plans were put in place to address any issues arising from these.

People were able to give their views on the service either informally, which is how most people told us they preferred to do, or formally in response to periodic surveys. Responses to surveys were analysed and actions or information provided as necessary.

Rushymead Residential Care Home

Detailed findings

Background to this inspection

The inspection was carried out over two days by an inspector and on the first day an expert 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. In this case they had experience of services for older people.

We carried out a planned inspection in September 2013 where we found breaches of legal requirements in respect of staffing. We carried out a follow-up inspection in January 2014 and found the provider had taken appropriate action and were no longer in breach of legal requirements.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We also looked at the notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send us.

During the inspection we spoke with 10 people who lived in Rushymead, nine members of the care staff team, a member of the housekeeping staff, two activities staff an administrator and the registered manager. We also received feedback from two other health and social care professionals and also spoke with relatives.

We looked at six people's care records, reviewed medication practice, and three staff recruitment records as well as staff training and supervision summaries for all care staff.

We looked at the way people interacted with staff and each other in communal areas, for example, lounges and dining areas.

Requires Improvement

Is the service safe?

Our findings

A system was in place to record and review incidents, for example falls. This process was used to inform assessments of risks to people, with action taken to reduce the likelihood of the incident recurring, where that was possible. However, potential risks to the safety of people were not always addressed as soon as they were identified. For example, in the morning, on a floor which included one person with visual impairment, a head-height cupboard door had been left open and there was a carpet cleaner left unattended on the corner of a corridor. We highlighted this risk to people from banging their head or tripping to the attention of staff. The carpet cleaner was moved after five minutes, however after lunch the cupboard door was still open. At the outside of the building to the rear, the patio paving was very uneven. This made it potentially hazardous for people who had mobility or visual difficulties who were able to access the garden. The registered manager was aware of problems with some areas of carpet in the home and short-term repairs with appropriate carpet tape were in place. The registered manager said the replacement of worn carpeted areas was to be addressed.

Recruitment records included details of the checks which should be made before people were employed. However, we found these had not always been fully completed or recorded. Disclosure and Barring Service (DBS) checks had been carried out in each case to obtain details of any previous relevant convictions. Whilst two references had always been requested, in one case only one reference was on file. We were told another reference response was awaited; however, the person had already commenced work. In a case where a DBS check included details of a previous conviction, the interview record did not provide evidence this had been followed up/considered, although we were told it had been but had not been recorded.

People told us they felt the service was safe. One said they had been; "Thinking how lucky I am to be here". People said they had no concerns about bullying or harassment and had not seen anything of concern for their own or other people's safety.

The number of staff required to safely meet people's needs had been assessed by the provider taking into account numbers and dependency levels. Staff were not rushed and had time to stop and talk to people. Meal times were busy, however, staff made sure people who required additional support to maintain their safety, received it.

People said they felt staffing numbers were sufficient to meet their needs. Call bells were answered promptly during our inspection. People told us this was usually the case during the day, although at night time it might be longer. One person said they had been; "Kept waiting to go to the toilet for thirty minutes sometimes" and that; "The staff say, wait a minute, and keep me waiting". However, two other people said the response time by staff at night was satisfactory.

The staffing had recently been increased to six in the morning and staff told us this had been; "An improvement" as it gave them more time with people as they helped them to get ready for the day ahead. This had also reduced the use of agency staff which provided more consistency for people who received care. The number of staff on duty throughout our visits over two days agreed with the staffing rota.

Arrangements were in place to protect people from abuse. Safeguarding training was included in staff induction and updated thereafter. Staff told us what the signs of different forms of abuse might be and how to report it. They had access to policies and guidance on safeguarding..

Staff understood the requirements of the Mental Capacity Act 2005(MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions, at a specific time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Where people were not able to make their own decisions, relatives confirmed they had been consulted. Care plans included the necessary documentation to support this, for example, where 'best interest' meetings had been held.

The service was meeting the requirements of the DoLs. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Three DoLS applications had been made to the appropriate authority at the time of our inspection, none of these had yet been determined.

Requires Improvement

Is the service safe?

People were given the opportunity to make choices. For example, about whether they took part in activities, where they sat and what they ate and where. People's human rights were recognised, respected and promoted and this was supported through staff training. For example people could maintain contacts with people who were important to them without unreasonable restrictions. People were helped to maintain religious observance if they chose to do so. People confirmed they were able to have visitors at any time. Advocacy services were available if people required them.

People's care plans included detailed assessments about potential risks to their health and safety. There was information about how identified risks could be eliminated or managed, for example, the risk of falling. Assessments of risks had been kept under review and updated where necessary. This helped keep people safe if risks changed over time. Reviews of their care involved the people concerned and their representatives where appropriate.

Records and procedures for the safe administration of medicines were in place and being followed. Storage was safe and records were kept of storage temperatures to make sure they were within required limits. There were no controlled drugs currently prescribed to people living in the service. There were appropriate storage facilities and means to record controlled drugs available if this changed.

Every person who received support with their medicines had an appropriate risk assessment in place. We looked at three people's medicines records in detail. They were accurate and balances of their medicines agreed with records. We saw records of a staff meeting which had included a session on good medicines practice, looking, for example, at recording, administration and implications of the MCA for the administration of medicines. This helped to update staff and reinforce good practice. People told us staff helped them with their medicines and had no concerns about the way this was done.

The premises were clean. There was appropriate colour coded cleaning equipment available to help reduce the risk of cross-infection between different areas when cleaning. There was also a poster displayed for staff explaining the colour coding of cleaning equipment. Staff received training in good infection control practice to enable them to protect people from the risks associated with infection. People said the home was always kept clean and tidy and that they enjoyed talking with the staff whilst they cleaned their rooms.

Records were in place to confirm equipment, like hoists and assisted baths, were properly maintained. Where people required specific equipment to keep them safe, for example pressure relieving mattresses and bed-rails, assessments were in place to show why these were required. People were involved in decisions about their use. Where people did not have capacity to consent to this, the correct procedures and safeguards were followed.

Good

Is the service effective?

Our findings

People said they were respected and felt involved in their care. Care plans included evidence that people were involved with the assessment, planning and delivery of their care. Care plans were reviewed with the involvement of the people concerned and those close to them where appropriate. This was confirmed in our conversation with people and their relatives. We also saw care plans had been signed by the person concerned or their representative. There were newly revised care plans gradually being introduced, these were designed to be clearer and more effective in establishing people's needs and their preferred way of meeting them.

One relative wrote; "Thank you for the very comprehensive annual review of my mother's care and other arrangements at Rushymead and for your time to meet with me". Another commented; "My mother was in Rushymead for five weeks respite care. She went in a frail; unsteady on her feet individual … she came out healthy, in a positive mind-set and able to return to her own home".

Care plans included records of people's end of life care wishes where these had been given. The PIR indicated there were seven Do Not Attempt Resuscitation (DNAR) agreements in place. Where people did not have capacity to make specific decisions, appropriate records were kept and processes followed to protect their best interests. Additional palliative care support was provided into the service when necessary.

Care plans included details of people's appointments made with community health services, for example, GPs, dentists and opticians. A community optician said they received appropriate referrals and were supported by staff when they visited people who needed their professional services. This showed people's health needs were monitored.

Speech and language therapy services were involved, for example, where people had difficulty in swallowing. One person said they had daily insulin injections and a weekly blood test by a community nurse, another was receiving care for a pressure ulcer from a community nurse and had pressure relieving equipment provided to help them.

Community healthcare professionals reported the standard of care they saw was good. They also said that liaison and co-operation between them and the service was good. In the PIR the service set out how they ensured all the relevant information was provided when people had to go to hospital or another external health service. This ensured key information was available to the other service.

We observed lunch in two parts of the home. The atmosphere was friendly and although staff were busy, they found time to talk to and encourage people during the meal.

People said they enjoyed the food. One person said; "The food is of good quality" however, they also noted, "We don't get enough fresh fruit and salad". Another person said they could always have soup or sandwiches if they didn't like the main option.

Care plans identified people who required their food and drink intake monitored because they were at risk of not eating or drinking enough. People's weight was monitored and appropriate action taken if they were not maintaining a healthy weight. Staff were aware of people's dietary requirements and showed us a typical diet sheet. One person, who was diabetic, had jelly instead of the usual pudding. We were told if a person changed their previous choice an alternative could be provided. This wasn't clear from the lunch we observed and only the previously chosen meals were available on the trolley.

Drinks were readily available and staff gave people a choice between hot or cold drinks. The food served was hot, however, on the top floor there was some confusion in serving people's meals as one person's pureed meal had not been labelled correctly.

Recently recruited staff had a structured induction and worked initially with more experienced staff to gain experience and confidence. Training was provided in different formats, including e-learning, distance learning, national vocational training and training provided by external specialists.

Staff had differing experiences of the frequency of one to one supervision. This was where they received support and guidance from the manager or a senior member of staff and could discuss any issues or concerns, including training and personal development. Estimates by staff ranged from 'rarely', 'monthly' or 'six each year'. The supervision record for July indicated all care staff had received supervision that month. Team meetings were said

Good

Is the service effective?

to be infrequent. Minutes of one team meeting were seen. Staff told us team issues were discussed at handovers between shifts and more informally between themselves, the manager and senior staff.

We saw letters from relatives and social care commissioners who paid tribute to the skills of the staff team. We saw training records which confirmed dementia care training had been provided, along with training in providing care for people who had suffered strokes or had some behaviour which could challenge a service. There was a designated dementia champion within the staff team to promote understanding and best practice for people living with dementia .They told us they did this through team meetings and on an individual basis with other staff members. There had also been a recent appointment of additional activity staff specifically to concentrate on activities for people living with dementia. One commissioner said, following a series of reviews they had carried out; "Rushymead was given the highest praise for the friendly, skilled and helpful staff". A relative wrote; "Mother is in the best possible place for her needs and care".

Good

Is the service caring?

Our findings

People told us care was good and staff were considerate and helpful. One person said "I have been thinking how lucky I am to be here" and another said "I love it here, service is good". Two relatives told us although they had some minor issues, overall they were; "Very satisfied" with the standard of care they saw. One relative wrote; "Staff are warm, kind and considerate, they valued my mother for the person she is…the care she received was outstanding." Another relative noted; "I have been greatly impressed by the resident-focussed ethos and truly amazed at the depth of the care and compassion exhibited by everyone in whatever role they have at Rushymead". A commissioner of care passed on comments from families made to them; "Both families described Rushymead as very much their loved one's home".

Staff interactions with people were positive. They used people's preferred names and people responded warmly. Staff asked people how they were as they passed by. They offered drinks to people throughout the two days we were there. We observed when a member of staff noticed a distressed person; they went to help them immediately, spoke in a calm and gentle way and reassured them. People said staff would knock on their door before entering and treated them with respect and preserved their dignity when providing support with personal care. One person said staff always respected their privacy "no complaints there."

During our lunchtime observation we saw when staff needed to help people, they did so in a respectful way and people's dignity was protected as they were treated sensitively and without attention being drawn to them in any way.

Health and social care professionals told us staff had been very proactive, co-operative and were responsive to any requests for information. This enabled people to receive any specialist health care they required in a timely and effective way. One G.P stated; "The service at Rushymead is safe, effective and very caring. The manager and all the staff offer high standards of clinical and compassionate care to the patients". A social care professional said the standard of care they had seen was very positive.

Staff had a good understanding of people they provided care and support for. They explained the key worker role and how they got to know people's life histories and preferences through one to one sessions completing a life history booklet. This included, for example, the time people liked to get up in the morning and go to bed at night and the events and people which were significant for them, for example, family and close friends..

One person said they preferred their own company and staff respected that. They had a settled staff team providing their support, which they found helpful and said they could; "Come and go as they pleased". They noted they could get up and have their shower 'whenever they want' with staff support.

Good

Is the service responsive?

Our findings

There were regular assessments of the level of people's needs and whether they had changed. Where they had, action was taken to address this and care plans were updated to reflect them.

We observed different parts of the service at different times of the day. This included early morning on the second day of our inspection when we could hear people were being helped to get ready for the day ahead. We sat with people and watched an activity session and lunchtime. People were offered choice and asked what they would like to do and when. Care staff were patient and interactions were positive. There was a particularly unhurried and peaceful feel to the home in the early morning. Staff were heard to ask people how they were feeling, what they would like to do and how they had been during the night.

Staff were provided with appropriate training, for example, in dementia care, to ensure they could effectively and safely meet people's needs. Where people had specific needs, trained staff and appropriate equipment were in place to meet them effectively.

There was a programme of activities, external entertainers and some occasional trips out. Provision was made for people who wished to maintain religious practice or worship. Additional activity staff had been recruited and were focussing on people living with dementia. The activities co-ordinators worked together to try and ensure a range of activities were available for people of all abilities. They also worked on a one to one basis with people whenever possible.

There were no regular formal meetings when either people or their relatives met together for discussions about the home and the way it operated. Individual reviews were used as an opportunity for people to comment and raise any matters of interest or concern for them. Relatives said they were able to raise any issues at any time on an individual basis.

People knew how to make a complaint if they needed to. They said they were most likely to raise any concerns they had informally with the staff or the registered manager. There was a formal complaints procedure in place and readily available to people and their relatives. In the information provided by the service prior to the inspection, they told us there had not been any written complaints made to them. In the same period they reported receipt of 13 written compliments.

Good

Is the service well-led?

Our findings

Rushymead is operated by a charitable trust. The board of trustees were active in the running of the service and in promoting its values as a not- for- profit organisation. Trustees had individual responsibility in monitoring various areas of the home's operation. The senior trustee made frequent visits to the home and trustees took an active interest in the standard of care and the environment. There were records of provider reports made on a regular basis, which covered key areas of the home's operation. Action plans to address any issues were then put in place and monitored by the trustees.

People were supportive of the culture and values of the service as a local, voluntary organisation. . One said; "Something within these walls is soothing," another noted they were; "Happy it is a small home". A health and social care professional noted they had received positive comments about the 'approachable and efficient' management of the home. One relative noted in a letter of thanks; "The management of the home was excellent…hands on and leads by example.."

People felt able to approach the registered manager and senior staff if they needed to. They said care staff were friendly and responded when asked for help. People were involved in reviews of their care, together with their relatives where appropriate. Relatives confirmed they had access to senior staff and felt able to raise any issues or concerns freely. There were no regular, routine service users' or relatives' meetings. However regular reviews of care involved people and their relatives. Community health professionals were positive about the level of communication and active co-operation they received from the registered manager and staff.

There was a system to record accidents and incidents. Where it was possible to do so, action had been taken to prevent these from happening again. The service had notified CQC appropriately of incidents and significant events as required to by law. The PIR included details of the process to monitor and identify trends which included consultations with staff. As a result of these, for example, an additional member of staff had been allocated for the early mornings to improve the experience for people by giving staff more time to provide their care..

Staff were aware of the service's whistle-blowing policy. This enabled staff to raise concerns at either a senior level inside or outside the organisation without negative consequences for

themselves. Staff said they felt able to approach the registered manager and management team at any time. One member of staff told us; "Management don't listen", however, they also noted staffing had been increased, which had been "positive".

We saw a summary of the results of a resident/relative survey carried out in June 2014. This identified 11 comments made and provided details of the action taken in response. For example, an additional activity organiser had been recruited to help increase one to one activity time for people; the variety of gluten free food had been improved, the variety and nutritional value of food was being improved and improvements had been made to the garden borders and how people's post was dealt with. This showed people had been asked to comment on the quality of the service they observed and that action had been taken to address any issues or concerns raised wherever possible.