Embrace All Limited

Rose Court Lodge

Inspection report

3 Sutton Road
Mansfield
Nottinghamshire
NG18 5ET
Tel: 01623 471300

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Ratings

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

Overall summary

This inspection took place on 23 and 24 November 2015 and was unannounced. Rose Court Lodge is registered to provide accommodation, personal care and nursing care for up to 110 people, although nursing care was no longer being provided. There are two separate buildings and one building (The Lodge) was not in use. 44 people were accommodated in Rose Court at the time of our visit. People were supported with a variety of physical health needs as well as dementia related care.

The service had not had a registered manager for a period of six months. The manager we have reffered to in this report was in the process of registering. 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. The registered manager was not present during this inspection.

Summary of findings

People felt safe and action was taken to keep people safe. Risks to people's safety were appropriately managed and staff also promoted people's independence.

There were sufficient numbers of suitable staff to meet people's needs and people received their medicines as prescribed.

When we last visited the service in September 2014 we found the provider was not meeting the legal requirements in respect of supporting staff, because regular supervision was not provided to all staff. During this inspection we found that, although not all staff had received recent supervision, progress had been made and staff felt well supported. Staff received a wide range of training although it was not always effective.

We found the Mental Capacity Act (2005) (MCA) was not being used correctly to protect people who were not able to make their own decisions about the care they received.This was a breach of Regulation 11 and you can see what action we told the provider to take at the back of the full version of the report.

Whilst sufficient quantities of food and drink were provided, there was a delay between the first and last people receiving their meals at lunchtime. Kitchen staff did not have access to up to date information about people's dietary needs. Support for people to access healthcare services was provided consistently.

Whilst the day to day decisions people made were respected, they were not always fully involved in planning and reviewing their care. Staff treated people with dignity and respect and there were positive relationships.

People were happy with the care they received, however care was not always responsive to people's changing needs. Staff did not always have access to information about people's needs. People felt able to make a complaint and the complaints received had been appropriately investigated and responded to.

When we last visited the service in September 2014 we found the provider was not meeting the legal requirements because improvements were required to the leadership of the service and governance systems. During this inspection we found that progress had been made although there was still further work to do for the service to become fully effective. The provider carried out a range of quality checks, however the manager had not had time to carry out the programme of audits available to them.

People were aware of different ways they could provide feedback about the service. There was an open and transparent culture in the home and everybody spoken with felt the manager led by example.

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.

People felt safe and the risks to their safety were well managed.

There were sufficient staff to meet people's needs.

People received their medicines as prescribed.

Good

Is the service effective?
The service was not always effective.

Staff felt supported although not all staff had received recent supervision. A range of training was provided to staff although it was not always effective.

Where people lacked the capacity to provide consent for a particular decision, their rights were not always protected.

People enjoyed the food and had access to sufficient quantities of food and drink. However, there was a delay in some people receiving their meals.

Staff ensured people had access to healthcare professionals.

Requires improvement

Is the service caring?
The service was caring.

There were positive relationships between people and staff and their privacy and dignity was respected.

Although people were not routinely involved in reviews of their care, the day to day decisions they made were respected.

Good

Is the service responsive?
The service was not always responsive.

People did not always receive the care and support they required and there wasn't always guidance for staff in people's care plans.

Complaints were investigated and responded to in a timely manner.

Requires improvement

Is the service well-led?
The service was not always well led.

There was a range of audits available to assess the quality of the service, however these had not been fully implemented. People and staff were able to feedback about the quality of the service and their comments were taken seriously.

There was an open and transparent culture in the home and people and staff felt the manager led by example.

Requires improvement

Rose Court 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 23 and 24 November 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor with experience in nursing care and 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. 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. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with nine people who were using the service, six visitors, five members of care staff, the manager and the provider's area manager. We also observed the way staff cared for people in the communal areas of the building. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care plans of seven people and any associated daily records. We looked at four staff files as well as a range of records relating to the running of the service such as audits and six medication administration records.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at Rose Court Lodge. One person said, "I'm completely safe here." Another person told us, "It feels safe. The staff and people here are all quite nice people, everybody seems friendly." We were also told, "I'm happy, I feel secure." The relatives we spoke with told us they felt their loved ones were kept safe.

The atmosphere in the home was relaxed and we did not observe any situations where people were affected by the behaviour of others. Staff told us they felt able to manage any situations where people may become distressed and we saw that a variety of techniques were used, such as holding the person's hand or walking with them to another area of the home. There was information in people's care plans about how to support them to reduce the risk of harm to themselves and others which staff were aware of.

Information about safeguarding and whistle-blowing was available in the home. Staff clearly described the different types of abuse which may occur and told us they would not hesitate to report any concerns. Staff had confidence in the manager and told us they felt the manager would act appropriately in response to any concerns. We saw that relevant information had been shared with the local authority when incidents had occurred. Where recommendations were made about how staff could better keep people safe, these had been implemented.

The people with spoke with were satisfied with the way in which risks to their health and safety were managed. We were also told that people were encouraged to be as independent as possible. One person said, "I need help with the shower and dressing, but they encourage me to do things myself." Another person said, "They let me do things, but they come and help me if I feel insecure." The relatives we spoke with were happy that risks to people were well managed.

We observed that staff encouraged people to carry out tasks for themselves where they were able, whilst remaining vigilant about their safety. For example, one person enjoyed walking independently but they were at risk of falling. Staff encouraged the person to walk by themselves with a walking aid and followed closely behind. Other people were provided with aids and adaptations so that they could carry out tasks such as eating and drinking independently. Staff were observed to use safe moving and handling techniques when operating hoists and stand aids to transfer people.

There were risk assessments present in people's care plans which identified the level of risk to people in different situations, such as the risk of falling. Staff had not always correctly completed the risks assessments, for example calculating a score incorrectly. However, the manager took immediate action to correct this and ensure staff understood how to complete risk assessments correctly.

People lived in an environment that was well maintained and preventable risks and hazards were minimised. Regular safety checks were carried out, such as testing of the fire alarm and actions were taken to reduce the risk of legionella developing in the water supply. Staff reported any maintenance requirements and these were resolved in a timely manner.

The people we spoke with felt that there were enough staff, one person commented, "They pop in even if I haven't called, they're very good." Another person told us, "Oh yes there are plenty of staff." The relatives we spoke with provided mixed feedback about whether there were sufficient staff. One relative said, "Sometimes there are not many staff about." However, relatives had noticed an improvement in staffing levels since the closure of The Lodge building. This had meant that more staff were working in Rose Court than had previously been the case. One relative said, "There are more staff here now."

We observed that there was generally a member of staff available to support people in the communal areas of the home. When people required help this was provided quickly. For example, one person had a treasured item which they liked to hold. When they dropped it staff responded immediately to pick the item up for them. We also saw that staff attended quickly to people in their rooms when a call bell was activated.

The staff we spoke with felt that staffing levels were safe and that since The Lodge had closed staffing levels had improved. One staff member said, "There is always someone available

to help with repositioning and hoisting." A regular assessment of the needs of people using the service was carried out and this determined staffing levels. The manager told us they were given the flexibility to put

Good

Is the service safe?

additional staff on the rota if they needed to. The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

People received their medicines when required and staff followed safe procedures when administering medicines. One person said, “I have just had my tablets this morning, no problems.” Another person commented, “They ask me every day if I need any pain killers.” We were also told, “They make sure I get my medicine.”

We observed staff administering people’s medicines and saw that they followed safe practice when doing so. Staff gave people their medicines at the correct time and were patient when people required some time or explanation prior to taking medicines. Staff correctly recorded the medicines they had administered to people on their medication administration records. Training in giving out medicines was provided to staff as well as regular checks of their competency in medicines administration. The records we checked confirmed that staff received regular support in the management of medicines. Medicines were stored securely in locked trolleys and kept at an appropriate temperature. There was a clear system in place which meant people’s medicines were ordered in time. Medicines which were unused or no longer required were disposed of safely.

Requires improvement

Is the service effective?

Our findings

When we last visited the service in September 2014 we found the provider was not meeting the legal requirements in respect of supporting staff, because regular supervision was not provided to all staff. The provider sent an action plan detailing the improvements they planned to make. During this inspection we found that progress had been made although there was still further work to do for staff to be fully supported.

The people we spoke with were not sure what training staff had received however commented that staff were competent in their duties. One person said, "Staff are all good." Another person told us, "They are pretty good – can't find any fault with them." We were also told, "Staff are good, they listen to me." The relatives we spoke with thought that staff were generally well supported and knew how to care for people. One relative said, "There are carers and carers. There are some that are very good." Another relative said, "It is okay for training, but there's always room for improvement."

Staff were provided with a range of training in important areas such as safeguarding and infection control. The majority of staff training was up to date and the manager showed us how their knowledge was checked through competency assessments and observations. However, the training staff received was not always fully effective. For example, the staff we spoke with demonstrated a limited understanding of how the Mental Capacity Act (2005) impacted on the care they provided to people.

The staff we spoke with felt supported and told us they could approach the manager if they needed support. A new supervision and appraisal system was being implemented by the manager and they had made progress in establishing this. Whilst not all staff had received supervision recently there was a plan in place for this to be addressed. The supervision records we saw demonstrated that staff were able to raise any issues they had as well as the manager assessing their performance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training regarding the MCA and DoLS however the staff we spoke with did not have an understanding of how this applied to the people they cared for. Staff were unsure who living at Rose Court Lodge had had decisions made in their best interests. Also, staff were unsure about who was subject to a DoLs authorisation, meaning that people may not be effectively cared for. The manager was aware of DoLS and applications had been made to the local authority where it was felt people needed to be deprived of their liberty.

People told us that staff asked for their consent before any care was provided and we observed this to be the case. However, people who may lack the capacity to make decisions did not always have their rights protected. Some decisions about people's care had been made without carrying out an assessment of their capacity to make the decision for themselves. For example, staff were administering one person's medicines covertly. Whilst consent to do so had been received from their GP, staff had not assessed the person's capacity to make decisions about their medicines. Additionally, some assessments of capacity that had been carried out were not properly completed. We saw assessments that were general in nature and not about a specific decision that needed to be made. This meant it was unclear if a decision was being made which may result in the person's rights not being respected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with thought the food was good and that they received enough to eat. One person said, "The food is spot on." Another person said, "There is always a choice. I like the food." We were also told, "It is good food,

Is the service effective?

nothing too fancy but just what I like." Another person commented, "The food has always been very nice, they vary it. The cook comes and finds out if it's okay." The relatives we spoke with also commented positively about the provision of food. One relative said, "The kitchen staff are very good. They will always make something else if [my relative] doesn't want what's on the menu." Another relative commented, "[My relative] has a good appetite and eats plenty, they have put on weight since they came in here."

People enjoyed their meals, however there was a delay of 30 minutes between the first and last people receiving their meals. By the time the last person received their meal, several people had already finished theirs. Some people had also been seated at a dining table for a long time before their meal was served. One person commented, "Meals get later and later." We observed that several people had fallen asleep whilst they were waiting for their meals and two people walked out of the dining area before their meal was served, although staff persuaded them to return later.

The kitchen staff were able to describe the different dietary needs that they catered for, such as providing pureed and low sugar foods. However, the list of people's dietary needs in the kitchen was out of date and the kitchen staff acknowledged it required updating. This meant there was a risk that people may receive food that was not suitable for them. During our visit we observed that individual requests people made were catered for. For example, one person requested tomato soup at breakfast and this was provided. People were also offered plenty of drinks during meal times and throughout the day. We observed that where people required some support to eat their meals this was provided at the person's own pace.

The people we spoke with told us they were referred to healthcare professionals, such as their GP, as and when necessary. One person told us they had recently had new glasses. A relative told us that their loved one had seen their dentist and 'had their teeth sorted out' since moving into the home. We observed that staff helped people attend their healthcare appointments in the community when required. Other appointments were carried out in the home and during our inspection we observed members of the local district nursing team visiting people.

The staff we spoke with reported that they had good relationships with the healthcare professionals they worked with. There was evidence that senior care staff contacted district nurses and the GP with any concerns about people's health and wellbeing. Staff contacted specialist services such as the dementia outreach team and dietician for advice and we saw records in people's care plans to confirm this.

Good

Is the service caring?

Our findings

People told us that staff were caring and that they enjoyed good relationships with them. One person said, "We all get on ever so well." Another person commented that the night staff were especially good. We were told that staff were, "Very caring," and also told, "I'm very comfortable here." The relatives we spoke with also felt that staff were caring, with one relative saying that care staff generally communicated well with their loved one. Another relative said, "I've never heard one staff member ever raise their voice at anyone."

During our inspection we observed that staff had warm and friendly relationships with people. Staff interacted with people in an individualised manner which showed that they understood people's personality and sense of humour. Staff were, at times, enthusiastic for example when trying to generate interest in some music that was playing. At other times staff displayed a calmer and more gentle approach. For example, one person had become disorientated when walking around the building. A staff member spoke gently with them and suggested they go for a walk round together.

The staff we spoke with told us they enjoyed working in the home and felt they had good relationships with people. There was information available in people's care plans about their likes, dislikes and family history. Staff were aware of this information and how it impacted on the care they provided to people. There was also information about any religious and cultural needs that people had, and access to religious services was available.

We received mixed feedback about whether people were involved in planning and reviewing their own care. The people we spoke with were not sure whether they had seen their care plans although did confirm that they provided information about their care needs on arrival at the home. Some of the relatives we spoke with had had discussions about care plans when their loved one had initially been admitted to the home. However, people told us that there wasn't a systematic review of care plans with them and their relations. One relative said, "I've not seen a care plan. I'm not sure if [my relative] is getting the care they need in the way they want it."

People's care plans showed that they were involved in making decisions about their care upon arrival at the home, although not all care plans had been signed to confirm this. Although people's care was reviewed on a monthly basis, people were not routinely involved in the reviews. We did observe that staff involved people in making day to day decisions such as where they wanted to spend their time. Where people had decided they preferred to spend their time in their own room these choices were respected.

People were provided with information about how to access an advocacy service; however no-one was using this at the time of our inspection. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People told us they were treated with dignity and respect by staff. One person said, "I like the staff, they are all kind." Another person told us, "It is pretty good, I can't find any fault with them. They always knock on my door." The relatives we spoke with also confirmed that staff treated people in a polite and respectful manner. We observed that staff were respectful towards everybody and used different approaches when talking with people, depending on their personality and their mood at the time.

The manager told us they were in the process of obtaining a privacy screen which would be used when people were being hoisted in a communal area of the home. A relative also commented that the manager ensured that people were always dressed in clothes of their choosing. The layout of the building allowed people to have privacy in their own bedroom or in a smaller, quiet lounge. Equipment was provided to support people to maintain their independence such as grab rails, raised toilet seats and assisted bathing adaptations. People could receive visitors at any time of the day and privacy was respected by staff.

Requires improvement

Is the service responsive?

Our findings

The people we spoke with told us that they received the care they needed and staff respected their independence. The relatives we spoke with were also positive about the care that people received. One relative said, "They're good at letting me know if something is not right, some are really good at knowing what's wrong." Another relative told us, "Staff always know when [my relative] has a water infection. They keep us well informed."

Despite the positive feedback we received people did not always receive care that was responsive to their changing needs. For example, one person had been gradually losing weight over a period of six months. Despite this weight loss staff had not assessed the person as being at risk of malnutrition, although staff had still contacted a dietician for advice. Staff were not following all of the guidance that had been provided because they were not recording the person's nutritional intake and hadn't always recorded their weight as frequently as suggested. This meant that staff had not taken all of the necessary steps in response to the continued decline in the person's weight.

Where there was evidence that a person was at risk of falling there was not always guidance available to staff in how to care for the person. For example, one person was assessed as being at medium risk of falling, however there was no care plan in place to advise staff how to manage this risk. Although the person had not fallen their care had not been planned in response to this risk. We saw however, that staff had responded well to changes in other people's needs. For example, some people were at risk of developing a pressure ulcer. Staff ensured that they had pressure relieving equipment in place that their position was changed on a regular basis.

Reasonable adjustments were made to support people with their communication needs. Staff ensured that people had hearing aids and glasses avaialble to them. Important information was provided in picture format to aid decision making. Staff also spoke clearly and patiently when people required extra time to understand information.

People told us that there was enough for them to do and they enjoyed the activities provided. One person said, "There is enough to do here, I like the activities, I like them all." Another person told us they, "Enjoyed going out to the garden centre." Another person said, "I like to watch the activities but I like sitting here as well."

The was a schedule of planned activities which took place during the week. During our visit many people enjoyed a sing-a-long and game of indoor skittles. In addition, one to one activities were provided such as a manicure or reading the newspaper. People were also supported with activities in the local community. Trips were planned to visit a local garden centre and for people to do Christmas shopping. The manager told us that they planned to increase the provision of activities at weekends.

The people we spoke with told us they would be happy to make a complaint and knew how to do so. One person told us they could, "Talk to any of the girls [staff]." Relatives were confident in raising any concerns or complaints they may have and thought that staff and the manager were approachable . One relative told us, "I wouldn't have a problem talking or complaining to anyone."

People were provided with information about how to make a complaint when they moved into the home. In addition, the complaints procedure was displayed in a prominent location. We looked at the records relating to complaints received in the past 12 months. We saw that they had been investigated in a timely manner and an outcome provided to the person who made the complaint. Where possible complaints were resolved to the satisfaction of the complainant. In addition, any lessons that had been learnt from the complaint were shared with the staff team.

Requires improvement

Is the service well-led?

Our findings

When we last visited the service in September 2014 we found the provider was not meeting the legal requirements in respect of the leadership of the service and governance systems. The provider sent an action plan detailing the improvements they planned to make. During this inspection we found that progress had been made although there was still further work to do for governance systems to become fully embedded.

There were different ways people could provide feedback about the quality of the service and these were utilised well. One person said, "I do go to the meetings here, they are good." Another person said, "I was given a survey to complete a while back." The relatives we spoke with told us their feedback about the service was respected and felt that action was taken wherever possible in response to any comments they made.

We saw that there were regular meetings for people who used the service and their relatives to attend. Comments people had made about the type of activities they would enjoy had been taken on board and changes made to the activity programme as a result. Surveys were also distributed to people and their families and these showed people were happy with the service they received. Any comments made by people were taken seriously and the actions taken were communicated to everybody, for example about improvements to the cleaning of people's wheelchairs.

Representatives of the provider regularly visited the service to carry out a range of audits such as an infection control audit and health and safety checks. These ensured that, where improvements were needed, they were implemented. For example, an additional size of disposable gloves had been purchased for staff to use. A range of audit tools were available for the manager and senior staff to use, although the manager had not been able to fully implement the schedule of audits they intended to carry out. For example, they had only had time to complete one care plan audit. We identified that there were issues with people's care plans during this inspection and a regular programme of care plan audits may have detected these issues sooner.

The people we spoke with felt the culture of the home was open and transparent. Relatives also commented that they felt there was a relaxed and friendly atmosphere and they would feel comfortable speaking with the staff or manager. During our visit we observed people confidently interacting with staff and the manager. We also saw that staff were comfortable speaking with the manager and regularly did so throughout our visit.

The staff we spoke with felt there was an open and transparent culture in the home. However, two staff commented that the recent movement of some staff from The Lodge to Rose Court had caused some friction. It was felt that staff were not always working well together or sharing the workload equally. The manager was aware of this and was in the process of meeting with all staff to discuss working practices. There were regular staff meetings and staff felt able to make suggestions and raise concerns during these meetings and they were taken seriously and acted upon.

The service had not had a registered manager for six months. The manager we have referred to in this report was in the process and registering and they understood their responsibilities. The majority of people we spoke with knew who the manager was and commented positively on their leadership. The relatives we spoke with felt that the manager was approachable and had made positive changes.

The staff we spoke with commended the manager and told us that if they were struggling the manager would be willing to help out. We saw the manager supporting staff and speaking with people in the communal areas of the home regularly during our visit. The manager also helped out when required and staff appreciated this, commenting that the manager led by example.

Sufficient resources were available to drive improvements to the service people received. For example, the provider had supported the manager to maintain a staffing level above that which they felt was required. The staff we spoke with told us that they were provided with the equipment required to support people well. Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not acted in accordance with the Mental Capacity Act (2005). Regulation 11 (3).