Barchester Healthcare Homes Limited

Rose Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
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 unannounced inspection took place on 06 and 07 November 2014 and was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

At our previous inspection on 11 June 2013 the provider was not in breach of the regulations we looked at.

Rose Lodge provides accommodation for up to 57 people who require nursing or personal care. At the time of our inspection there were 54 people living at the service. The service had a registered manager in post. They had been a registered manager since 26 September 2014. A registered manager is a person who 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.

People told us they were safe living at the service and staff were knowledgeable about reporting any abuse.

Summary of findings

However, we found that there was not always a sufficient number of suitably qualified and trained staff employed by the provider. People were not assured that their care needs would be met in a timely manner.

The provider's recruitment process ensured that only staff who had been deemed suitable to work at the home were employed. This was after all pre-employment checks had been satisfactorily completed.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager was knowledgeable about when a request for a DoLS would be required. However, only two out of seven staff were able to tell us when a person would need to be considered for a DoLS application. In addition, restrictions placed on people's freedom had not been authorised by a supervisory body.

All staff respected people's privacy at all times. People were not always provided with their care when this was required and people sometimes had to wait over two hours for their care needs to be met. This meant that people's dignity was not always respected.

People's assessed care needs were planned and, in most cases, met by staff who had a good understanding of these and how to meet people's needs effectively. However, administration and recording of people's prescribed medicines was not always undertaken accurately.

Care was provided by staff in a caring and compassionate way. People's hobbies and interests had been identified. However, there were limited opportunities for people to be supported with these. Records also confirmed the limited social stimulation people had been provided.

People were supported to access a range of health care professionals. People were consistently supported by the appropriate health care professional in a timely manner. Health risk assessments were in place to ensure that people were safely supported with their health risks.

People were provided with a varied menu and had a range of healthy options to choose from. People with complex care needs, including those people at an increased risk of malnutrition or dehydration, were supported with appropriate food and drink. There was a sufficient quantity of food and drinks available at all times in the home.

A complaints procedure was in place. Complaints had been recorded and responded to. This was to the satisfaction of the complainant. People could raise concerns with the staff at any time.

The registered manager and staff were not always supported effectively. This included not having sufficient staff and staff whose training, supervisions and appraisals had lapsed.

The provider had quality assurance processes and procedures in place. We found that these had not always been effective in identifying the issues we found. This put people at an increased risk of unsafe care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People were not always safely supported with their prescribed medicines. People were supported by staff who were knowledgeable about procedures to help protect people from harm.

There was not always a sufficient number of suitably experienced staff employed at the service to meet people's needs.

Only staff who had been found to be suitable to work with people at the service were offered permanent employment.

Is the service effective?

Requires Improvement

Staff had an understanding of the Mental Capacity Act 2005 (MCA). However, the registered person had not advised staff when an application for Deprivation of Liberty Safeguards DoLS was required. This increased the risk of people having care that was not in their best interests.

People were not always supported by staff who had up to date training and support.

People were supported to eat and drink a balanced diet, especially those with complex care needs. Sufficient quantities of nutritious food and drink were always available. People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People were provided with their care and support needs with compassion and in a sensitive and caring way.

Staff knew each person's needs and they responded to people's requests for support.

Prompt action was taken to ensure people's care and support needs were met by the most appropriate health care professional. People were given opportunities to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A limited range social activities and hobbies were in place for people to access. Activities and stimulation was limited.

People were able to raise concerns or complain if they needed to. The provider had an effective complaints procedure in place.

Summary of findings

Regular reviews of people's care were completed and changes were made to ensure people's care was provided in the way they wanted it to be.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had not always informed the Care Quality Commission about important events that occurred at the service.

Audits and checks completed by the provider were not always effective in identifying areas for improvement.

The provider used a variety of ways which it supported people to be able to suggest improvements, raise concerns and comment on the quality of care it provided.

Rose Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 06 and 07 November 2014 and was undertaken by two inspectors 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.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also spoke with the service's commissioners, a health care professional and a GP.

During the inspection we spoke with 11 people, three relatives, the registered manager, 10 care staff members and the chef. We also observed people's care to assist us in understanding the quality of care people received.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at eight people's care records, staff records and service user, relatives' and staff meeting minutes. We also looked at medicines administration and safeguarding procedures and complaint records and records in relation to the management of the service such as, electrical and lifting equipment inspections. We also looked at staff recruitment, supervision and appraisal planning tools, and training records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with confirmed that they were safe living at the home and that they had no concerns about the care they received. One person living on the ground floor said, "The staff treat me ever so well and I have my call bell at my side and staff usually come when I call." However, a staff member said, "Due to the number of staff on nights we don't always get to provide or meet people's continence needs. This means some people can be wet for up to two hours until the day shift starts." Another member of staff said, "We could do with more staff in the morning." A relative said, "They could do with more staff, especially in the morning when it's busy." The registered manager told us that they were aware that the staff distribution was not correct and more staff were needed upstairs, especially between 6.00am and 9.00am.

The registered manager told us that when people started to use the service their dependency levels were assessed and staff was provided according to this. They used a "patient a day" assessment to ensure on-going care needs were met. They told us that the budget was then set by the provider for staffing levels. We found, especially upstairs that staff had little, and in some cases, no time to spend with people in a meaningful way. Three out of eight staff and two relatives told us that there was not always enough staff on duty. One care staff said, "If people want to go outside we sometimes have to tell them that they could go out tomorrow instead." One person who needed help to get to the toilet said "There is usually good response to the bell but not always". Another person told us, "It sometimes takes a long time for them to answer the bell." This meant that people's needs were not always met in a timely manner.

This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

On the second day of our inspection at 10.15am there were eight people who had not had their personal care. The registered manager told us it was the provider's philosophy that personal care could happen at any time. Service user meeting minutes had also identified that the night shift staff were not always quick enough to respond to requests for assistance to go to the toilet. This showed us that some people had to wait for their care.

Staff demonstrated a good understanding of what protecting people from harm meant. The registered manager told us and staff confirmed that they kept up-to-date with current safeguarding practices and would report any concerns if they ever needed to. Access to information about protecting people from harm was available in the home, including in the service user guide. This showed us that there were measures in place to help ensure the risk of harm to people was minimised.

The staff administered medicines to those who needed it. One person said, "The staff give me my medication and stand there while I take it." However, we found that people were not always safely supported with their prescribed medicines. Three out of seven staff told us they had not had regular medicines administration training including the application of topical creams. Records for the administration of medicines had not been completed or were inaccurate. In addition, it was unclear if people were given their medication as prescribed as there were three discrepancies in the quantities of medicines held compared with the quantity which had been administered. Not all medicines were stored correctly including diabetes medicine not being stored at a safe temperature. Staff were not able to explain why this was not in, or how long it had been out of, the fridge. This put people at risk of being administered medicines which did not contain their manufactured properties. Therefore, we could not be assured that the quality of people's medication was maintained.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Staff recruitment records we looked at showed us there was a robust process in place to ensure staff were only employed at the service after their good character had been reliably established. Checks included those for criminal records, previous employment history and references from employers. Staff confirmed that they had only started work after these checks had been completed. This showed us the provider only employed staff who were found to be suitable to work with people living at the home.

Processes and procedures were in place to ensure that the risk of harm to people was managed effectively. Risks to people's health had been identified and were safely managed. Examples included people, who were at risk of

Requires Improvement

Is the service safe?

dehydration and malnutrition, being weighed regularly and having their fluid intake monitored. This helped ensure people at an increased risk were safely supported with their health and wellbeing.

Accidents and incidents were recorded by the provider and these records were analysed for any trends. Where these had been identified we saw that prompt action had been taken to help ensure that the potential for any future recurrence was minimised. Examples of this included people who had experienced falls, failure of equipment and medicines administration errors. This information was shared with managers of the provider's other homes to help identify preventative measures. This meant that the provider was proactive in recording and managing accidents and incidents.

Due to concerns reported to us about hygiene in the home we looked at infection prevention and control processes. We found that staff followed good infection prevention and control procedures and maintained a good standard of cleanliness in the home. This included dust free surfaces, use of colour coded cleaning equipment and segregation of contaminated bedding and clothing. A visiting heath care nurse told us that home always smelt and looked clean. People could be confident that their care was provided in a home which was cleaned to an appropriate standard.

Requires Improvement

Is the service effective?

Our findings

People told us and we saw that staff were often very busy and there was limited time for talking or engaging them in activities. We saw that staff were task driven and had limited time to engage in meaningful conversation. One member of staff said, "We do have a lot of agency staff which doesn't help with people's continuity of care. Most of the agency staff are nurses and they only provide nursing and little else." Another person said, "I have led such a busy life but now I'm bored most of the time."

Staff confirmed that they had not all had regular training, especially since the deputy manager had left in May 2014. This included training for medicines administration, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Five out of seven staff had an inadequate understanding of the MCA and DoLS and what this meant for each person. One person's care plan contained a capacity assessment stating that they lacked capacity. However, there were no details on the specific capacity and decisions the person could or could not make. The record was a general conclusion that the person lacked capacity to make any decisions. There were also no best interests decisions on what care was in this person's best interests. For example, medicines administration or the use of covert medication. This increased the risk that people would not always be supported with care that was in their best interests.

We found that restrictions were in place to prevent people who asked to leave from leaving the service. One person did not have a DoLS authorisation or application in place and their freedom had been restricted unlawfully. They were under constant supervision and had made several attempts to leave and on more than two occasions they had to be distracted to get them to return to their room. We looked at this person's care plan. We found that no best interests decision had been made or recorded regarding the restrictions on this person's freedom. The registered manager told us that they had a completed an example of a DoLS application form for staff but assessments had not yet been completed. This meant that this person's liberty had been restricted unlawfully.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Training records we viewed confirmed that most staff had not had all their training. Between September 2014 and October 2014 the training statistics for staff had not reached the expected level of 85% or more. One staff member said, "It wasn't until I did some of my training two weeks ago that I realised that some people were being provided with care that was not in their best interests." The registered manager told us that they had identified, that staff supervision and appraisals had lapsed. This meant that people could not be assured that their care was provided by staff whose training and support was up to date.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

One staff member explained their induction and that they had found it helped them, with staff support, to become confident. They told us they had a three month probation supervision and their next one was due at six months. Staff had an effective induction to the home. Other staff who had worked at the home for some time felt that their induction had been good but changes had taken place since then.

We saw that staff understood people's needs well. This was by ensuring they always received a valid consent from each person before providing any care or support. Examples we saw included staff understanding people's body language or facial expressions where people were not able to tell staff when they wanted to go to the toilet or were in pain. People were provided with care by staff who had a good understanding on how to meet people's needs where they had agreed to this.

People's care plans included advanced directives including do not attempt cardio pulmonary resuscitation (DNACPR) records. Some of these were on the provider's own documents and contained all the information required by the emergency services. This showed us that current DNACPR guidance was followed.

One person told us, "I get plenty to drink. I get to choose and the choices are wonderful."

People were provided with information of the meal menu options in advance or by means of a visual sample of the choice available for people who have difficulty in remembering. In addition, people were asked what they would like and said that there was always an alternative choice if they changed their minds.

Requires Improvement

Is the service effective?

During our SOFI observation we saw that people were supported in the dining area or a place of their choice with their meal. This was done at a pace people found acceptable. However, people who used a wheelchair had to stretch at the table which had not been adapted for them. This meant that for these people the meal experience was not as dignified or respectful as it could have been. Staff attended to people's dietary needs, sought their agreement to support people and offered additional quantities if required. One person said, "I can't get to the dining room but staff bring me snacks and help me with my meals." This and records viewed showed us that people were provided with a sufficient quantity to eat and drink.

People told us, and we found, that they saw a range of health professionals including opticians and a GP when they needed. People's health conditions were monitored regularly and where health care professional support was required we saw that this had been provided promptly. One person said, "If you want a doctor they will get one straightaway." We also saw that changes in people's medications had been identified and implemented. This meant that people were supported with their health care needs.

Good

Is the service caring?

Our findings

People spoke highly of the staff and felt they were treated with respect and as individuals. One person said, “I’m quite happy here and if I want anything I only have to ask. “Most staff are alright but they all do their job.” Other comments were, “The staff are all very good.” A relative said, “I’m generally very satisfied with the care my [family member] has received and this is the best home in the area. If anyone asked me I would certainly recommend this place.”

One example of the care provided was a person whose [family member] visited every weekday and had lunch with them in the dining room. Another relative told us, “I visit every week at different times and it is never a problem. They always acknowledge me and ask how I am.” People were supported to see relatives without restriction of visiting times.

People’s care needs were assessed prior to living at the home including how they wanted to be supported in following their religious beliefs. People’s needs had been supported with information from families, friends and staff to ensure these could be met and supported whilst respecting people’s independence. One person told us, “Coming here has revived my faith in human nature” and “Nothing seems too much trouble for them.”

People told us that they were asked if they wanted anything or help but staff also respected people’s independence. One person asked to go to the toilet and we saw that this was responded to discretely and without fuss. Another person said, “I can’t recall ever being unhappy with the staff. I hadn’t expected this level of care.” They also said, “The staff do whatever you ask and nothing is ever any trouble.” A visiting GP commented that people’s care was provided and based upon what people had requested and needed.

People’s care records were held securely and daily care records were used to record the care people had received. A relative said, “If anything ever happens to [family member] the staff call us straight away and tell us what is going on.” Staff told us and we found that any changes to people’s care was recorded and that people were informed of what this meant for them.

We found that staff only discussed people’s care when this could not be overheard by other people or other visitors. We observed one person being hoisted. We saw that staff continued to talk with the person throughout the move and ensure the person did not become anxious. This person was seen smiling after the move. This showed us that people were supported in a way which respected their dignity.

Is the service responsive?

Our findings

People had a pre admission assessment to confirm their care and support needs and what was important to them such as their preferred hobbies and interests. One person said, "I like knitting and I am supported to do this." Another person said, "There are lots of communal activities such as singing and games which I like to take part in."

People's care plans were detailed and included guidance for staff to follow. Examples included people's preferences and choices had been recorded for the clothes they liked, whether to bath or shower and what time they liked to eat. One person told us, "The staff know what I like best and I can't complain." A visiting GP commented that people's care was based upon people's individual needs and that the staff had good skills in liaising with the GP practice, on a daily basis, in response to people's health changes.

There were examples of care being focussed on the individual. One person said, "It's not bad here, the carer has taken me round the grounds in my wheelchair." Another person using memory cards was helped by staff when they had completed turning these over. However, we saw there was a lack of organised hobbies and interests which people wanted to do. Indoor activities were limited to Bingo every Thursday and a quiz sheet which was handed out every week and for completion in people's own room without much meaningful support. Most people occupied their time reading or watching television. There was a visiting mobile library and there was a minibus for outings but this was on an 'as and when' basis. One person said, "We have trips out now and again – we went to Hunstanton the other week."

One staff member said, "If anyone has a concern or wants to complain about something, I report this to the registered manager." People were given every opportunity to raise concerns, if they had any, about their care and action was taken where required. All of the people we spoke with told us that it would not be a problem if they had to make a complaint. One person said, "If you have a complaint you take it to (pointing to staff) and they will see to it". Another said, "If I had to complain I would tell reception and then they would send someone, usually the [registered] manager, to see me." We found there were no unresolved complaints. This showed us that complaints or concerns were addressed promptly and to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us that there had been a change in management and they knew where their office was. They said that they could speak with the senior nurse at any time but they saw little or nothing of the registered manager. Three staff also told us that they rarely saw the registered manager around the home. The registered manager told us that due to the absence of the deputy manager and an administrator a lot of their time had been taken up doing other tasks which meant they were not able to get on the 'shop floor' as much as they had planned. This meant that some tasks including reviews of people's care plans had been delayed.

The home had a registered manager who had been in post since September 2014. We found the registered person had not always submitted notifications to us. (A notification is information about important events the provider must tell us about, by law) to the Care Quality Commission when this had been required. They told us that they had informed the safeguarding authority but had gone on leave and forgotten to notify the Care Quality Commission. On another occasion, again, the registered person had failed to notify the CQC about suspected abuse. This put people at an increased risk of harm as not all regulatory authorities had been informed without delay.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Visiting health care professionals and the Cambridgeshire and Peterborough Clinical Commissioning Group told us that they had no concerns with the way the home was managed. This showed us that the leadership of the home was well thought of by organisations external to the provider.

The registered manager told us the key challenges were catching up on lapsed supervisions, using much less agency nurses, completing appraisals and getting back to basics with all staff training. They told us that they knew where improvements were needed but now that a deputy manager and administrator were in post the situation would improve from now on. Staff meeting minutes we looked at for the 30 October 2014 showed us that the registered manager had a clear plan on how to improve the home, what the current issues were and how these would be resolved. They also showed that the visions and values of the home in achieving and then maintaining a high standard of care had been clearly set out. Staff were aware of their roles and responsibilities and how to escalate any issues to the registered manager or provider using the correct channels.

Regular checks and audits were completed in relation to people's medicines administration and environmental health and safety. However, we found that these checks had not identified the medicines administration and recording errors we found during our inspection. Not all of the provider's audits were therefore effective.

One person said, "I can always tell the [registered] manager anything. I don't need to wait for any meetings." They also said, "They act on our concerns and we have never had to raise a formal complaint." Another person said, "I attend the 'residents'' meetings and I can raise anything that I am not happy about." One example of this was a change from paper to cloth napkins at mealtimes. This showed us that people were involved in developing the service.

Information on whistle-blowing (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work) in policies and procedures was available for all staff. The registered manager and all staff told us that they were confident that if ever they identified or suspected poor care standards they would have no hesitation in whistle-blowing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who use services were not protected against the risks of unlawful restrictions on their freedom.** Regulation 11 (1) (b) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use services were not protected against the risks of unsafe management and administration of their medicines.** Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People who use services were not always provided with their care when they wanted or needed this to be provided.** Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People were not assured that they were cared for by staff who had up to date training and support.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 23 (1) (a)
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had failed to notify the Care Quality Commission without delay of safeguarding and abuse incidents or allegations of abuse. Regulation 18 (1) (2) (e)