Rose Cottage Care Limited

Rose Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Rose Cottage Residential Home is registered to provide accommodation and nursing care for up to 38 people. At the time of our inspection there were 34 people living at the service. The service is a single storey premises located in the village of Broughton near the towns of St Ives and Huntingdon. Most of the rooms have en-suite bathrooms. Each room has a call bell system, a telephone and TV point, and access to the internet. The service is based in a rural location, has landscaped gardens and a naturally occurring pond.

This unannounced comprehensive inspection was undertaken by one inspector and took place on 3 February 2017. At the previous inspection in January 2015 the service was rated as 'Good'.

A registered manager was in post at the time of the inspection and had been registered since the service was registered in 2010. At the time of inspection the registered manager was on leave. 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.

Staff had been trained on how to keep people safe and they knew who they could report any incidents of harm to. However, we found that not all incidents of harm or potential harm had been reported or acted upon. This put people at risk of harm and meant that organisations responsible for investigating safeguarding were not able to respond in a timely manner to assure people's safety.

Not all risk assessments were in place. This increased the risk of people being exposed to a risk of harm.

A sufficient number of appropriately recruited and suitably skilled staff were in post to safely meet people's assessed needs.

Medicines were managed safely by staff whose competency had been assessed. Where medicines' administration errors had occurred, action had not always been taken to assure people's safety. This put people at risk of harm.

Staff possessed the necessary care skills to meet people's health and nutritional needs. Health care support from external healthcare professionals was requested by staff in a timely manner.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. Appropriate authorisations were in place to lawfully deprive people of their liberty. Staff did not always have a good understanding about the application of the MCA code of practice and how care that was in the person's best interests was determined.

People were looked after with respect for their dignity. Staff provided care that was compassionate and in consideration of each person that was cared for.

People, their legal representative or relatives were enabled to be involved in identifying, determining and planning the review of their care.

People were supported to be as independent as they wanted to be where this was safe. People could take part in their hobbies, interests and pastimes. This stimulated people and prevented the risk of isolation.

An effective system was in place to gather and act upon people's suggestions, concerns and complaints. Actions taken in response to people's concerns were effective in preventing the potential for recurrence.

The registered manager was supported by a deputy, four team leaders, care staff, as well as catering and maintenance staff. Staff had the support mechanisms in place that they needed to fulfil their role effectively.

The registered manager and provider had not always notified the CQC about important events that, by law, they are required to do. People, their relatives and staff were involved and enabled to make suggestions to improve how the service was run. Quality monitoring and assurance processes were in place. Not all improvement actions identified were acted upon.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

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.

Not all accidents and incidents were reported to the appropriate authorities. Not all risks had been correctly assessed. This put people at risk of harm.

Medicines were not always managed safely.

People's needs were met by a sufficient number of staff who had been recruited in a safe way.

Is the service effective?

Good

The service was effective.

Staff were trained and provided with the right skills to support people with their independence.

Appropriate authorisations were in place to lawfully deprive people of their liberty.

People were supported to access health care services and people had sufficient quantities to eat and drink.

Is the service caring?

Good

The service was caring.

People's care was compassionate, kind, respectful and was provided with dignity.

Staff used people's care plans to the benefit of each person they cared for.

People had the support and advocacy they needed and relatives could visit at any time.

Is the service responsive?

Good

The service was responsive.

People were enabled to contribute to the assessment and planning of their care.

People accessed a wide range of pastimes, hobbies, interests and other opportunities to help prevent the risk of social isolation.

People's comments, concerns and complaints were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager and provider had not always notified the CQC about events that, by law, they are required to do so.

Quality assurance procedures and systems were in place to help drive improvements in the quality of care that people were provided with. However, these were not always as effective as they could have been.

Staff were supported in their role in an open and honest manner which fostered a positive staff culture.

Rose Cottage Residential Home

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 3 February 2017, was unannounced and was undertaken by one inspector.

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 looked at this and other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

Prior to the inspection we made contact with the local authorities who commission people's care, including social workers. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

We spoke with six people and five relatives. We also spoke with the owner (provider), a visiting GP, the deputy manager, two team leaders, two care members of staff and the chef.

We observed how people were cared for.

We looked at five people's care records, medicines administration records and records in relation to the management of staff and the service.

Requires Improvement

Is the service safe?

Our findings

We found that staff had been trained as well as being deemed competent in the safe administration of people's medicines. Records we viewed showed that staff recorded medicines' administration correctly. However, we found that people had not always had their medicines as prescribed. In addition, where an incident had occurred of people not being administered their medicines as prescribed, health care professional advice had not always been sought. We also found that the appropriate safeguarding authorities had not always been informed where neglect had occurred, due to an error in administering medicines. Medicines were not always managed as safely as they should have been. The provider told us in their PIR submitted in December 2016 that one area for improvement was in the audit of medicines' administration.

One staff member said, "I have undertaken regular medicines' administration training and then I was observed a few times before I was signed off [as being competent]." Our observations showed that staff prompted people to take their medicines as prescribed such as with water. People could be as independent as they wanted with taking their medicines. Another person confirmed to us that they had all their prescribed medicines on time.

Risk assessments had been completed and covered those areas where people may be at risk such as from moving and handling, skin integrity, malnutrition and falls. We did find however, in some care plans we looked at, that where people had a bed rail or a behaviour that could challenge others a risk assessment had not been completed. In addition, there was no guidance on the areas staff needed to check such as the gaps between the mattress and the bed rail or the timings for any checks. The lack of information limited staff's ability to be able to demonstrate how risks to people were minimised and put people at risk of harm. Staff were however able to tell us the checks that they had undertaken to help ensure people were protected from harm as well as the interventions to manage people's behaviours. The deputy manager told us that they would address this straight away. We saw that a team leader had updated people's risks from bedrails before we completed our inspection.

People told us that they felt safe because staff attended to their needs promptly. One person said, "If you call them [staff] they come quite quickly. If there is ever a reason for a delay they tell me the reason for this and when they will help me." A relative told us, "There have been some changes in staff recently but my [family member] has never had to wait more than a few minutes." This is what we observed during our inspection. We found that there were sufficient staff in post to meet people's assessed needs.

Staff had been trained in protecting people from harm and they were knowledgeable about who they could report any concerns to such as the registered manager or the local safeguarding authority. One staff member said, "If they [registered manager] was doing anything they shouldn't I would speak with the owner [provider] or call the CQC." A relative told us, "Whenever [family member] needs to get up staff are there quickly and make sure the walking frame is used." Care staff were able to describe to us how they would identify any, or potential, harm. For example, by the person having bruises, being withdrawn or just not their usual self. One person told us, "I need two staff to help me and there is always two. I feel safe as I am well

looked after when they lift me."

Records we viewed and staff who we spoke with showed us that appropriate checks had been made to establish staff's suitability to work with people using the service. These checks included two previous employment references with any gaps in employment explained. This was as well as an enhanced Disclosure and Barring Service (DBS) check for any unacceptable police records. The deputy manager told us, "When we recently recruited some more staff we asked for photographic identity, proof of good health, proof of address as well as (evidence of) any qualifications." A staff member said, "I had to wait for my DBS to come back (clear) before I started. People were assured that the staff providing care had been subject to appropriate recruitment checks to determine their suitability to work with people.

Good

Is the service effective?

Our findings

People's needs including people's capacity to make decisions were assessed prior to using the service. As a result of this and the planned training and support staff had received, people were provided with care by staff who were skilled, knew people well and met their care needs. One relative told us, "They [staff] couldn't have known my [family member] better. They made such a difference to [family member's] life." One person told us, "They [staff] know me so well they rarely have any need to ask me what I need. They always ask me for permission first though." People could be confident that their care was provided by staff who were supported in their role.

Staff told us that the support they received had enabled them to do their job effectively. One team leader told us, "All new staff undertake the Care Certificate (a nationally recognised qualification in care). They have an induction which is as flexible to each new staff's development as it needs to be." A care staff member said, "We get lots of training in house as well as external training on subjects such as the MCA (Mental Capacity Act 2005)."

The 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. We checked whether the service was working within the principles of the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the relevant authorities and where these had been authorised the registered manager and staff were adhering to the terms of each person's DoLS. However, we found that for some people care that had been determined as being in the person's best interests had not been documented. A relevant person's representative had been appointed for people who were being deprived of their liberty, to ensure that their interests were being safeguarded. Although a discussion had taken place regarding the use of bed rails this had not been determined as being in the person's best interests. This limited staff's ability in determining people's care that was as least restrictive as practicable.

Our observations, and records we viewed confirmed that people were supported to eat and drink sufficient quantities of food and fluid. People had a choice of meals that they preferred. One person said, "The food is excellent." The chef showed us how those people who required a diet appropriate to their needs, such as a soft food or pureed diet, were provided with this. Another person told us, "We always get two choices and it's always nice and hot. If I wanted something else I can have it."

We observed how staff supported people to help ensure they ate and drank to maintain their wellbeing.

People could choose from a selection of menu choices or their own personal choice as well as snacks, fruit and drinks throughout the day. Records viewed showed us that people had a choice of a healthy balanced diet of nutritious foods. Where people were at an increased risk of malnutrition appropriate support was in place to help ensure they maintained a healthy weight.

People's health needs were met with the care and support that they were provided with. A visiting GP for the service told us, "They [staff] definitely know people's health care needs well, whatever information I need they have this." One relative said, "My [family member] always received first class [health] care." People were assured that their healthcare needs would be responded to. Where healthcare professional's advice had been provided, staff had adhered to this guidance. This was confirmed in records we looked at and from what staff told us. For example, for people's diets, repositioning to prevent pressure areas as well as using equipment to manage people's health conditions.

Good

Is the service caring?

Our findings

Our observations throughout the day showed us that staff provided people's care with kindness, dignity and compassion. Staff were attentive to each person and considerate of their needs which had been recorded in people's life history. One person said, "It's like living at home. I am looked after like royalty." Another person told us, "One thing you can count on here is being well cared for." A relative told us, "My [family member] was cared for with such consideration of their needs and at a time in their lives that, to me, was the most critical." The provider confirmed in their PIR that, "Most recent residents' and relatives' survey provides 100% agreement to questions about being treated with dignity, kindness and respect."

People were made to feel they mattered and they could be as independent as they wanted to be. For example, staff frequently sought assurance as to each person's wellbeing. One staff member was heard asking a person, "Would you like me to get you a jumper"? Another staff member said, "I'll get your wheelchair and I won't be long." We saw how staff knocked on people's bedroom doors and gained permission before entering. People's private information, care records and privacy was maintained. Staff achieved this by making sure people's doors and curtains were closed and securing personal records safely. One person told us, "They [staff] only ever talk about me [not about other people]. They do respect my dignity."

Staff gave us examples of how they respected people's privacy and dignity. For example, one staff member said, "I always make sure I cover people with a towel when doing personal care, have a conversation, make them as comfortable as possible whilst letting the person do as much as they want to themselves." A team leader told us, "I often help staff with moving and handling and if this is in a public area we always ensure people's privacy and dignity is respected. I say, let's go to your room rather than words such as toilet or bathroom." Our observations throughout the day confirmed that people were well looked after.

Staff supported people to be involved in their care with regular private conversations and meetings. We observed how staff encouraged people's independence. One person told us, "I can have as much support as I want. I do most things myself." Staff demonstrated the values of the provider such as "people do not live in our work place, we work in their home." This enabled people to have an informed choice about how they wished to live their lives. One person told us, "I am really looked after exceptionally well. For instance, things I wouldn't bother about they [staff] do. I am made to feel special every day."

People could be visited at any time they preferred. A relative told us, "I can even stay overnight with [family member] if the situation required this." We found that in addition to formal advocacy other arrangements were in place such as people with a lasting power of attorney and informal advocacy through national organisations. An advocate is a person who is able to speak on the person's behalf and make sure that the person's wishes and preferences are respected.

Good

Is the service responsive?

Our findings

People, their relatives, representatives, staff and the registered manager contributed to the assessment and planning of each person's care. This helped provide a foundation upon which each person's care needs were met. People's care plans reflected their needs, preferences, life histories, and what was important to them. One person said, "My [relative] does all that [planning] for me. If I need anything [about their care] changed it gets sorted." Another person whilst smiling said, "I love doing puzzles and jig-saws and I can do this in my room, the lounge or go into the gardens in the warmer weather."

To assist staff support people with their abilities each person had a one page profile in their care plan called "about me". This included guidance for staff about the person such as favourite pastimes, reading a magazine or book, foods, interests and hobbies. We found that people were enabled to take part in a wide range of these interests including taking part in quizzes, doing jig-saws, chatting with staff and going out on a coach trip. One person told us, "We are always doing something. It is always busy. You choose how busy you are." A relative said, "[Family member] was supported with the choices and we had such a lovely time celebrating their [special] birthday with a party and cake."

Other individual aspects of where people lived included appropriate items of furniture, pictures and ornaments which reminded people living with dementia of when they were younger as well as assisting people's orientation around the service.

Regular reviews of people's care plans had been completed. We saw that where actions had been required, such as referrals to a health care professional, changes to a person's care (including more one to one time) as well as new medicines or diet, they had been acted upon. One team leader told us, "Each person has a member of staff whose role includes updating care plans but I check that these are accurate, reflect the person and their needs." Records we viewed confirmed this.

People and relatives told us that they were satisfied with how each person's needs were met. One person said, "I have never had to complain" and "If I had any concerns I just pop to the office and they [staff] sort it." One relative told us, "They [staff] definitely meet all my [family member's] needs. They are considerate and nothing is too much trouble." Records of complaints showed us that they had been resolved to the complainant's satisfaction. We sat in on a staff handover and found that concerns were acted upon. People were assured that any concerns, suggestions or complaints would be taken seriously and actions put in place to prevent recurrence.

Requires Improvement

Is the service well-led?

Our findings

From records we looked at we found that there had been three occasions where the provider and registered manager should have informed us about important events that, by law, they are required to do. The appropriate actions had not always been taken such as informing safeguarding or a health care professional for advice. The lack of reporting limited the CQC's and other authorities' ability to respond accordingly where this may have been required.

This was a breach of The Care Quality Commission (Registration) Regulations 2009 regulation 18.

At this inspection we found that the provider and registered manager were prominently displaying their previous inspection rating. At the time of our inspection a registered manager was in post but they were on leave. They were supported by a deputy manager, three team leaders, care staff, as well as catering, housekeeping and maintenance staff. Staff had the support mechanisms in place that they needed to fulfil their role effectively. For example with support from experienced staff, meetings, appraisals and supervision by management.

Various quality assurance, monitoring and audits were in place for subjects such as medicines' administration, care plans and staff's adherence to various policies. Although we found that these audits had identified some areas for improvement, not all issues had been identified or acted upon. These included a lack of best interest meeting records, incomplete risk assessments and medicines administration errors. This limited the provider's ability to improve the service as effectively as they could have.

We received positive comments from a health care professional, commissioners of the service, people and their relatives about the leadership that the registered manager provided. Comments from staff included, "they are very approachable and listen to what I have to say"…..."I get the support I need when I need it". A GP who was providing people's healthcare told us, "[Registered manager] is always there if you need them. The staff have the knowledge I need which makes my job easier" and "I am sure that if there was anything needing attention that they would sort it out. I have never had any issues." A relative said, "[Family member] lived here for [a number of] years. Everything runs like clockwork. I would recommend this place to anyone." A team leader told us, "[Registered manager] is very proactive, they listen to what people and staff say and encourage us all."

People's and staff's feedback was sought through a suggestions' box, daily contact with the registered manager and deputy manager, and staff and residents' meetings. Meeting minutes we looked at showed that people's suggestions had been acted upon such as improving the quality and presentation of the fish. One person told us, "I like living here as it is everything that is perfect. I wouldn't change a thing."

Staff meetings and observations by team leaders were used as an opportunity to praise staff as well as reminding staff of the standard of care expected from them. For example, to correctly complete people's repositioning and other intervention charts such as fluid intake. We found that these had been completed correctly.

Other feedback had been in the form of compliments including, "Thank you for all [family member's] care. You [staff] have all been brilliant." We found that people accessed the community through coach trips, visits to a local restaurant, a private counsellor and visiting religious organisations. People told us about all the different pastimes, hobbies and interests that they had undertaken. One person said, "I love the trips out. We went on a tour of the villages [taking part in Christmas lighting] which was wonderful. Another person said, "There are visits from singers, musicians and we even had some tamed wild birds. I loved the owl."

Staff were provided with opportunities to make suggestions and contribute to improving the quality of people's lives and the care associated with these. For example, by having regular contact with the registered manager. One member of care staff said, "I have a supervision with a team leader every few months. I can always speak to them urgently if something crops up with a high priority such as a change in a person's health or new equipment that may be needed. Another staff member told us. "We had a really good course as a trainer came to highlight sensory impairments. We used equipment and this helped us understand a person's life with such impairments."

The registered manager and their team of staff sought people's views on a daily basis by asking if there was anything that could be done. Staff were heard asking people if they "liked the quiz"…."was there anything I could do for you" and "is the food to your liking". We found that people were complimentary about all aspects of their daily living. A relative told us, "There is absolutely nothing they [staff] could do better."

Staff told us, and information on display throughout the home confirmed that the provider used various external sources such as Public Health England to inform staff's knowledge. Updates such as the provision of care and medicines' administration were available. The provider told us in their PIR that "We use on-line resources such as Skills for Care (a nationally recognised body for care staff's training such as the Care Certificate) and CQC's own website. As members of national organisations including those for nursing homes and Care England (where information on various care organisations was accessible) we have access to their newsletters and on line resources." The provider said that recruitment had been a challenge but many staff remained loyal to the service and had been there over 10 years. This helped people to receive a consistent standard of care.

Staff were aware of the service's whistle blowing policy, how and when to use it. One team leader told us, "I make sure when walking around and doing my job that all the staff team maintain a high standard of care. If any staff drop below this they are reminded to improve. Any repeated poor performance means at least an interview." One staff member said, "You never know if working with a team leader if they are checking what you are doing. I always assume they are." All staff were consistent in their passion for making as much difference to people's lives as possible.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had not ensured that statutory notifications had been submitted to the Care Quality Commission (CQC). The lack of reporting limited the CQC's and other authorities' ability to respond accordingly where this may have been required. This was a breach of The Care Quality Commission (Registration) Regulations 2009 regulation 18.