Linkline Care Limited

Roseneath Care 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?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 2 and 4 March 2015. Both days were unannounced so no one knew we would be inspecting. We last inspected the home in 6 June 214. At that inspection we found that the provider was not meeting regulations relating to the monitoring of the quality of the service. We did not receive an action plan about how the issues were going to be addressed and some of these issues were found to be ongoing at this inspection.

Roseneath provides care and accommodation for up to 30 people who have needs relating to mental health, old age and frailty. The premises are not purpose built and as such there are a variety of bedroom sizes.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We found that there were some quality monitoring systems in place but they were limited and did not show that the provider was monitoring the quality of the service provided. Some improvements were being made to the fabric of the building but there was no time scale in which this would be completed.

Some people were not able to make decisions for themselves and required close supervision to keep them safe. How people who did not have the ability to make decisions for themselves were supported to make decisions was not always recorded. We saw that some applications had been made under The Mental Capacity Act Deprivation of Liberty Safeguards (MCA/DoLS) to ensure that their human rights were protected. Some applications had expired and not been reviewed, evidence was not available for others to indicate whether they had been approved or that the appropriate applications had been submitted. This meant that people's Liberty may have been restricted without the correct authorisations in place.

This is a breach of three regulations and you can see what action we have asked the provider to take at the end of this report.

We saw that interactions between staff and the people who lived at the home were friendly, polite and helpful to people. All the relatives and people spoken with were happy about the care their relative received.

All the staff we spoke with understood their responsibilities to protect people from harm and abuse. Staff told us that they were provided with the training that they required to carry out their role and keep people safe but safeguarding alerts were not always raised so that their responsibilities were not always fulfilled.

Our observations and conversations with staff and relatives confirmed that staffing numbers and the skill mix of staff was adequate to meet people's needs and to keep them safe. Staff had been appropriately checked before they started their employment in the home.

The management of medicines was not always safe because medicines were not stored and recorded appropriately and not all staff were knowledgeable about the systems for the safe management of medicines.

All the people spoken with told us they enjoyed their meals.

People knew who to speak with if they had any concerns. Relatives told us the provider was available to speak with if needed.

Some surveys had been sent out and a meeting had been held to get the views of people about the service.

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?
The service was not always safe.

Staff were aware of their responsibilities to keep people safe and the actions they would take if they had any suspicions about abuse. However, safeguarding alerts were not always made in a timely manner so other professionals were not able to monitor that people were protected from preventable abuse.

There were adequate numbers of appropriately recruited staff available to support people.

People did not always get their medicines as prescribed and the management of medicines was not always safe.

Requires Improvement

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

Staff had received training to support them to carry out their roles effectively but training was not always put into practice.

Adequate safeguards were not always in place to ensure that people's human rights were protected.

People enjoyed the meals they received.

People received support to have their health needs met.

Requires Improvement

Is the service caring?
The service was caring.

Staff were caring and responsive to people's needs.

Privacy and dignity was maintained and people's independence was supported.

Good

Is the service responsive?
The service was responsive.

People were involved in planning their care and received care according to their care plans. Regular reviews ensured that changes in care needs were identified and planned for.

There were appropriate pastimes for people to be involved in and people were supported to maintain contact with their relatives. People knew who to speak with if they were not happy about things.

Good

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

Inadequate

Summary of findings

The registered provider had failed to ensure that there was a registered manager in post with the required skills, knowledge and experience to manage and develop the service.

Audits systems were not in place to ensure that a good quality service was provided to people. There was no plan and monitoring system to ensure that the required refurbishment was completed as planned or actions taken to ensure completion as soon as possible.

Roseneath Care 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 2 and 4 March 2015 and was unannounced and was carried out by one inspector.

We reviewed the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We also looked at information shared with us by the Birmingham Local Authority who is responsible for commissioning services for people.

During our inspection we spoke with five people that used the service, five relatives, three staff and two health care professionals. We observed interactions between people and the staff. We also spoke with the manager and briefly with the registered provider. We looked at safeguarding, complaints and medication records. We also sampled three people's care records and audits used by the provider to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People spoken with told us they felt safe and were happy in the home. One person told us, "Yes I feel safe." We saw that people were comfortable in the presence of staff and interactions between staff and people were friendly and supportive. Staff spoken with were able to describe the different forms of abuse and the different agencies they could refer any concerns to. Staff confirmed that they had received training in how to recognise and respond to incidences of abuse. We saw that further training dates in safeguarding people from abuse had been arranged. Safeguarding alerts were not always raised in a timely manner. During and following our inspection we saw that there were incidents had occurred that should have been raised with the local authority but had not.

We saw that risks to people had been identified and plans put in place to minimise them. One person who went out alone told us they informed staff when they went out and the expected time of return. This meant that staff could take actions to identify the person's whereabouts if they did not return on time. People who smoked cigarettes were made aware of the risks of smoking in their bedrooms and had been provided with a smoking area so that they could smoke in a safe environment. We saw that risks such as skin damage, mobility and falls had been assessed and plans put in place to manage them. Equipment such as hoists and lifts had been serviced and maintained so that they were safe to use. Emergency situations, such as a fire in the home, were discussed with staff during meetings so that they knew what to do in the event of a fire.

Staff had been appropriately recruited and staffing levels were sufficient to support people appropriately. One person told us, "There are staff around usually." A relative told us, "They have a nice representation of staff who are generally sitting with the residents." Our observations confirmed that there were sufficient staff available to supervise and meet people's needs at all times. We saw that staff had time to sit and talk with people. Staff spoken with told us there were sufficient members of staff to meet people's needs. Staff spoken with told us that recruitment checks had been carried out before they started work. On both days of our inspection we saw that there was no chef available and the provider told us he was trying to recruit a new chef. On the second day of our inspection people told us they had been waiting for over an hour for their lunch. We saw that people were getting annoyed and some started to get up from the dining tables and had to be encouraged by staff to wait a little longer. People had been waiting for a takeaway lunch to be brought in for them. This showed that there was a shortage of catering staff in the home to prepare meals for people.

People told us they had their medicines on time. We saw that people knew which medicines they were prescribed. At tea time one person told the manager, "I have two little tablets at lunch time as well as these." The manager explained to the individual that they had different medicines at different times of the day and the individual was satisfied with the explanation. We saw that the manager administered medicines appropriately and observed people to ensure that they had taken the medicines before completing the medication administration records (MARs). We looked at the medicine administration records (MARs) for nine people. For one person the number of tablets remaining in the box showed that the individual had been given two tablets more than had been recorded as administered. Another person who should have had cream applied four times a day was only having it applied once.

Requires Improvement

Is the service effective?

Our findings

There were no capacity assessments in place to show what decisions people without capacity were able to make themselves and who was to be involved in making decisions on their behalf. Staff were able to tell us how they supported people for example, one person that wanted to go out was taken to the park, shopping or distracted with other activities. The relative of this person confirmed that the individual was taken out by staff. The manager told us that no training had been provided for staff regarding the Mental Capacity Act 2005 (MCA) or the requirements for the Deprivation of Liberty Safeguards (DoLS). The manager told us that three people were subjects of DoLS authorisation. We saw that one person's DoLS approval had expired and had not been renewed. The manager was not aware of this. There was no system in place to identify when DoLS authorisations needed to be reviewed. For the other two people we saw that urgent applications had been made but there was no evidence that they had been agreed or that standard authorisations had also been applied for. This meant that the requirements of the MCA Deprivation of Liberty Safeguards had not been met and people's rights may not be protected. This was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People and relatives spoken with told us they were happy with the care provided. One person told us, "It's nice here; staff give me the support I want." Relatives and friends spoken with told us they were happy with the level of care people received. One relative told us, "I am happy that mum receives the level of care she needs." We saw that staff were confident in supporting people and knowledgeable about the needs of the people they supported. Staff told us that they had received induction training so that they knew how to carry out their roles. The training matrix showed that there had been a variety of training including infection control and using the hoist but some of the training needed to be updated. The manager showed us that some updates had been undertaken and others had been planned.

People told us that they enjoyed their meals and we saw that people's dietary needs had been assessed and plans put in place to ensure that identified needs were met. Three people were able to tell us what they had chosen for their midday meal. Another person told us, "I had porridge for breakfast." We saw that people who had problems with swallowing or were losing weight were referred to the dietician for advice. We saw that one person was appropriately supported to eat their meals which were presented in a pureed form as required.

People were supported to have their health needs met. One person told us that they had fallen and had been taken to hospital to get treatment. Another person told us they had been assisted to hospital for a discussion about treatment they could receive. One relative told us that their family member's health was monitored by the home. Another relative told us, "[Person's name] health has deteriorated but the staff always call the doctor and keep me informed. [Person} was referred to hospital where it was identified that their medication needed to be changed. We are waiting for other hospital appointments to arrive." We saw that there was a nursing project involved in the service that supported the staff to prevent people being admitted to hospital unnecessarily and that advised staff on good practices. We saw that one person had a medical need that they were usually able to manage themselves however; there were occasions when staff had to assist. There was a care plan in place however the description of the actions taken by the manager were very different to the care plan. Staff told us that they had supported the individual on some occasions but they had not received training to undertake this procedure. The manager confirmed that no training had been provided. This meant that on occasions staff were supporting people without the appropriate training and could not be sure that the procedure was carried out correctly.

Good

Is the service caring?

Our findings

Staff were caring towards people and we saw kind interactions and good relationships had been developed. People told us that the staff were caring. One person told us, "The staff are nice." Relatives spoken with told us that staff were nice. One relative told us, "[person] is quite close to a lot of the carers." We saw that staff were compassionate and understanding of people's emotional states. We saw that one person was reassured about his wife's whereabouts and another person was comforted when they became upset about a friend who had recently passed away.

People and relatives told us that they were happy with the care provided. One person had commented in a meeting, "I definitely like living here." Another person told us they were "well cared for". We saw that people were comfortable in the presence of the staff and we heard people laughing and joking with them whilst playing games. Staff chatted with an individual whilst they were assisted to eat their food even though they were unable to respond verbally with them. We saw that people were dressed in individual styles. For example, one person wore a tie and jacket and another wore a hat. This showed that staff were aware of people's likes and dislikes and treated them as individuals and supported them to express their individual styles in the way they dressed.

Records showed that people or their relatives had been involved in planning their care. One person told us that they had had some health checks and was having further tests before they decided on the course of treatment. Records of meetings showed that people were supported to make choices about what they did. Choices were available to people for example, they could choose where they sat and what they did. We saw that some people spent the majority of their time in their bedroom whilst others sat in the lounge areas. However, we saw that at the evening meal only some people were offered toast with their baked beans and although there was a choice of sandwiches available people were not asked which sandwiches they wanted. The manager told us that this was not what usually happened.

People were supported to remain as independent as possible. We saw that people had access to equipment to enable them to walk independently, go out independently and to access cigarettes and lighters so that they were able to smoke cigarettes when they wanted them. Staff told us that they asked people about the help that they wanted and enabled them to carry tasks they could do themselves.

We saw that people's privacy and dignity was usually maintained. A relative told us that their family member's bedroom was kept locked whilst they were not occupying it to prevent other people wandering in. We saw that staff asked people discreetly if they wanted to be supported to the toilet and explained to people what they were doing when they supported people to other areas of the home. People were dressed in individual styles that reflected their personalities.

Good

Is the service responsive?

Our findings

Where possible people were involved in the assessment and care planning process. Where people were not able to contribute friends and relatives were involved in care planning and reviews of care. One relative told us, "I was asked about [person's] needs and likes and dislikes but her preferences have changed with time. Staff are aware of these." Another relative confirmed that they had been involved in planning care and their views had been respected. One relative told us that staff recognised when people's needs changed and had referred them either for medical treatment or moved to a more appropriate placement.

Staff were aware of people's individual preferences and cultural requirements. One relative told us their family member received personalised care, for example in respect of skin care. Another relative told us, "Changes are made where possible to accommodate changing needs. For example, we have discussed the need for a change of bedroom due to [person] needing more supervision."

We saw that were a variety of things for people to do. We saw that some people played games on either a one to one basis or on a group basis. Some people went out unescorted on a daily basis and other people were taken out by staff to the local shops so that they could buy personal items. Some people were happy to potter around the home chatting to people. We saw that people enjoyed the games and having their nails manicured.

During our inspection we saw that friends and relatives were able to visit throughout the day. Relatives told us there was no restriction on visiting people.

Most relatives spoken with confirmed that they felt comfortable to speak with staff or the registered provider to raise any concerns they had. One relative told us, "There is always a senior on duty, I also have the owner's number and I can ring him up." Another relative told us, I would speak to a social worker but I would feel comfortable to speak with staff at the home." A third relative told us they would speak to the manager but wasn't sure who to speak with at the moment as there was no manager in post. Records showed that complaints had been investigated and responded to appropriately. We saw records of relative's survey that showed that people were generally happy with the service but had raised some issues about clothes getting mixed up and mislaid. Relatives told us that they had had a meeting recently where they had raised concerns regarding the management of laundry. The manager confirmed that this had been raised and she was looking at ways in which to improve the management of laundry.

Inadequate

Is the service well-led?

Our findings

There had not been a registered manager in post since April 2012. The manager overseeing the home since that time had left the service in January 2015.There was an individual who was overseeing the service in the role of manager at the time of this inspection. The registered provider had failed in their duty to comply with their condition of registration to ensure that the regulated activity accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations. This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

At our inspection of June 2014 we found that systems in place to enable relatives comment on the quality of the service were not at accessible times or flexible to enable them make their views heard. The complaints record was not an accurate reflection of all the complaints made so that the provider could not be assured that all complaints were recorded and used to improve the service. The provider had identified that some improvements were needed to the premises in January 2014 but these had not been addressed six months later. We found some health and safety risks and issues relating to the monitoring of the cleanliness of the premises.

At this inspection we saw that refurbishment of some bedrooms was ongoing and the exterior of the building had been painted. There were improvements to the cleanliness of the premises. We saw that the systems to monitor the quality and safety of the environment were still not effective. For example the replacement of flood damaged ceiling tiles had not been replaced although they had been identified in an audit in January 2014. We saw that curtains were falling down in the lounge areas, the dining room floor needed to be repaired as it created a trip hazard and a dining room chair brought to our attention by a member of staff had to be removed from use as it was broken. These issues would have been identified if regular audits were carried out but we saw no evidence of these. . There was a maintenance list for repair jobs to be done but there was no plan of works so that progress of the refurbishment plans could be monitored and progressed in a timely manner. This would ensure that people had a pleasant environment in which they lived and they could feel comfortable in.

There were some systems in place to get the views of people about the service. There had been a recent staff, resident and family survey which indicated that people were happy with the service provided. Records of previous surveys or meetings were not available as the manager was not aware of them and could not locate them. No audits or checks were carried out to monitor the quality of the service. There was a complaints log that showed that complaints had been responded to appropriately but there was no evidence to show how they had been used to improve the service. We asked the manager what other systems were in place to monitor the quality of the service and was told that there were none.

The registered provider had not ensured that they had fulfilled the legal requirements. For example, they had not complied with a condition of registration to employ a registered manager. The manager that had been employed did not have the experience, skills and knowledge to manage the home to ensure that people were protected. We saw that the manager was not aware of the legal requirements. For example, during our inspection we identified that the manager should have alerted the local authority and us about a safeguarding alert but they had not taken the appropriate action to ensure the risk of harm to people was reduced. We asked the manager to make this safeguarding alert. However, a week later this had not been done. We saw that the management of medicines was not well organised and people did not always receive their medicines as prescribed and there was not always an accurate record of medicines in the home. We saw that one person who had an injection every three months was unable to have it at the prescribed interval because it had not been ordered in time. When we spoke with the nurse that administered the injection we were told that the nurses were supposed to order the injection. This showed that the manager was not aware of the system for getting the injection.

Where training had been provided the provider did not have systems in place to ensure the learning was put into place. For example staff had received training in the safe management of medicines but medicines were not always safely stored and recorded when received into the home. The manager was not fully aware of the systems in place for managing medicines and would be unable to provide support to staff as this was a role they had delegated.

Inadequate

Is the service well-led?

We saw that the systems to ensure that people's human rights were protected were not always effective. One person's authorisation to deprive them of their liberty had time lapsed and the provider did not have an effective system to apply for a review in a timely manner so that the person was not deprived of their liberty in an unlawful way.

This was in breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There was some involvement with the local community. The service had been involved in a nursing project that supported them to prevent unnecessary admissions to hospital. People were supported to use community services such as the local church and shops.

People that lived in the home were able to tell us who the manager overseeing the service was and we saw interactions that showed that people were comfortable in the manager's presence. Staff told us that they found the current manager to be accessible, supportive and available for advice. Staff told us they felt able to raise concerns with the manager and they would be acted on.

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 How the regulation was not being met: It was not always recorded how people with limited capacity to make decisions were supported to make decisions and the appropriate agreements to legally impose restrictions on people were not always in place. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 (Registration) Regulations 2009 Registered manager condition How the regulation was not being met: There was no registered manager in place. Regulation 5(1)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Adequate systems were not in place to ensure that the registered provider was assessing, monitoring and improving the quality and safety of the services provided to people. Regulation 17(1)(2)(a)(b) and (d)(ii)

The enforcement action we took:
Warning Notice