Parkcare Homes Limited

Rose Lodge Care home

Inspection report

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Banks
Southport
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 and to look at the overall quality of the service.

The inspection visit at Rose Lodge Care Home on 05 August 2014 was unannounced.

Rose Lodge Care Home provides care and support for a maximum of 40 older people. At the time of our visit there were 37 people who lived at the home. The home is set in its own grounds, located in Banks close to Southport.

Accommodation is situated on the ground floor and there is easy access for wheelchair users and the less mobile. All rooms have an en-suite facility and are situated over three wings. Communal areas include a lounge, a quiet room, a dining room and a landscaped outside area for people to use.

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

Summary of findings

Suitable arrangements were in place to protect people from the risk of abuse. People told us they felt safe and secure. Safeguards were in place for people who may have been unable to make decisions about their care and support.

The registered manager assessed staffing levels to ensure there was enough staff to meet the needs of people who lived at the home. We observed staff made time for people whenever required and took time to explain things to people so they didn't feel rushed. However, people who lived at the home told us there was not always enough staff on duty, which meant sometimes they had to wait to be supported. We saw there was a range of group activities taking place. However people who lived at the home told us there was not always the opportunity for people to receive time with staff on a one to one basis for activities. This meant people may be at risk of becoming socially isolated.

We looked at how medicines were prepared and administered. We found that two people's medication records did not match the quantity left in stock. Failing to give people their medicines properly places the health and welfare of people at unnecessary risk. This is a breach of Regulation 13 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.

We found inconsistencies relating to people's involvement in decisions about their care and how they were supported to make choices as part of their daily life. Most people had a detailed care plan which covered their support needs and personal wishes. We saw plans had been reviewed and updated at regular intervals. This meant staff had up to date information about people's needs and wishes. Records showed there was a personal approach to people's care and they were treated as individuals. However one person who had recently been admitted to the home did not have a complete care plan in place.

Staff spoken with were positive about their work and confirmed they were supported by the registered manager. Staff received regular training to make sure they had the skills and knowledge to meet people's needs.

The management team used a variety of methods to assess and monitor the quality of the service. These included satisfaction surveys, 'residents' meetings' and care reviews. Overall satisfaction with the service was found to be positive. However systems to monitor the health, safety and well-being of people who lived at the home, had not been effective in identifying areas where people's safety was compromised. This included administration of medicines, care planning for new admissions and ensuring adequate staffing levels to consistently meet people's needs. We found the provider did not consistently have regard to the comments and opinions expressed by people who used the service in relation to the quality of the service provided. This is a breach of Regulation 10 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?
The service was not safe.

People were not protected against the risks associated with medicines. This was because we found errors in the recording of medicines administered to people who lived at the home.

On the day of our visit we saw staffing levels were sufficient to provide a good level of care and keep people safe. However people told us this was not always the case.

Policies and procedures were in place around the MCA, DoLS and safeguarding. Staff had a good understanding of these to keep people safe and protect their human rights. However the documentation we reviewed for one DoLS application was not in order. Any restriction on this person would, therefore, have been unlawful.

Requires Improvement

Is the service effective?
The service was effective.

Staff had access to on-going training to meet the individual and diverse needs of the people they supported.

People were assessed to identify the risks associated with poor nutrition and hydration and spoke highly about the quality and choice of food.

Good

Is the service caring?
The service was caring.

People told us that staff were caring and attentive. We observed this during the inspection.

We saw that staff treated people with patience and compassion and respected their rights to privacy and dignity.

Good

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

Records showed people and their family members had been involved in making decisions about what was important to them. People's care needs were kept under review and staff responded quickly when people's needs changed.

However some aspects of the service were not responsive to people's needs. We found that risk assessments were not in place for one person who had recently been admitted to the home.

Requires Improvement

Summary of findings

People told us that they were not routinely asked for their opinions on the care they received.

There was a programme of group activities. We observed people participating in a range of activities during the day. However, where people chose not to participate in group activities, we found no provision was made for them to undertake activities individually or spend one to one time with staff.

Is the service well-led?

Requires Improvement 

The service was not always well led.

The provider had systems in place to monitor and assess the quality of their service. This included a range of audits and meetings for people to raise issues or make suggestions.

However systems to monitor identify, assess and manage risks to the health, safety and welfare of the people who lived at the home were not effective. This was because we found errors in medication records and care plans were not in place for one person recently admitted to the home. Also, there was inconsistency in drawing up action plans to address shortfall identified by audits.

Rose Lodge Care home

Detailed findings

Background to this inspection

The last inspection was carried out on 09 May 2013. This inspection highlighted minor concerns with safeguarding vulnerable adults due to a lack of staff training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We followed up on these concerns during this inspection and found improvements had been made.

The inspection team was led by an Adult Social Care inspector who was accompanied by a second inspector 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. The expert by experience for the inspection at Rose Lodge had experience of providing nursing care.

Before our inspection on 05 August 2014 we reviewed the information we held on the service and the service provider. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. This helped inform what areas we would focus on as part of our inspection.

We spoke with a range of people about the service. They included the registered manager, seven staff members, eleven people who lived at the home and three visiting family members. We also spoke to the commissioning department at the local authority in order to gain a balanced overview of what people experienced accessing the service.

During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spent time looking at records, which included people's care records, staff training records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were prepared and administered. We saw people's medicines needs were checked and confirmed on admission to the home. Where new medicines were prescribed these were promptly started. Pain monitoring was in place where needed and written guidance was in place for medicines prescribed 'when required', to help ensure consistency in their use.

Only trained staff administered medication. This was confirmed by talking to staff members.

The registered manager confirmed that periodic medication audits took place. This meant there was a system in place to ensure medication was ordered, administered and recorded in line with the home's policy and procedure in respect of medication administration.

We checked six people's medication records. On two people's records we saw a number of errors that raised concerns about how medicines had been administered. We found that one person who should have prescribed cream applied twice a day had not received the treatment for two days. We also found that one person had not had their prescribed medication on one evening. There was no reason for this recorded on the medication records. Failing to give people their medicines properly places the health and welfare of people at unnecessary risk. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were safely kept and we saw appropriate arrangements for storing, recording and monitoring controlled drugs (medicines liable to misuse). Storing medicines safely helps prevent mishandling and misuse.

We spoke with people about the management of their medicines. They told us they were happy for staff to administer the medication and had no concerns. One person told us they liked to self-administer some of their own medicines and confirmed they had everything they needed. Written assessments of safe self-administration had been completed, to help ensure that should any support be needed it would be consistently provided.

We looked at how the service was being staffed. We did this to make sure there was enough staff on duty at all times, to support people who lived at the home. We looked at the staff rotas and spoke with the manager about staffing arrangements. We saw staff members were responsive to the needs of the people they supported. Call bells were responded to quickly when people required assistance.

However we received negative comments from people who lived at the home about the amount of time staff have to spend time with them. People told us: "Some days and nights it's difficult, a lot of people press the buzzer. The staff are always busy, they could do with one more member of staff at night."; "Sometimes they are a bit short but they cope." When asked whether they thought there were enough staff, one person replied: "No, they take a long time to get to me."

We spoke with staff members about staffing levels at the home. One staff member told us; "We can't give enough baths/showers, and there's no time for conversation."; "Sometimes, usually when people go off sick we are short." Another member of staff told us; "Staffing levels are a problem. A lot of people require two staff to transfer. People do have to wait to receive care and we don't have enough time."

We spoke with the registered manager about the feedback we had received. They told us the staffing levels were regularly reviewed to meet people's needs and dependency levels. However in light of the feedback received they would review staffing levels, to ensure there was a consistent level of staff to meet people's care and support needs.

People who lived at the home told us they felt safe when being supported. One person told us; "Yes, I trust them all." Another said; "I feel perfectly safe." Relatives we spoke with told us they were confident their relative was safe in the care of the home.

The service had procedures in place for dealing with allegations of abuse. Where incidents had occurred, we saw detailed records were maintained with regards to any safeguarding issues or concerns, which had been brought to the registered manager's attention. This evidenced what action had been taken to ensure that people were kept safe. We saw safeguarding alerts, accidents and incidents were investigated. Where appropriate, detailed action plans had been put in place to prevent recurrence. This demonstrated the home had a system in place to ensure managers and staff learnt from untoward incidents.

Requires Improvement

Is the service safe?

Staff were able to confidently describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people who used the service were protected from potential harm or abuse. Training records confirmed staff had received training on safeguarding vulnerable adults. This included care staff as well as domestic, kitchen and maintenance staff.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated a good awareness of the code of practice. This meant clear procedures were in place to enable staff to assess people's mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We looked at the records for two people for whom applications had been made under DoLS. We saw capacity assessments had been carried out appropriately. We saw evidence that family members and professionals involved in people's care had been involved where decisions had been taken for the person. This helped to ensure decisions that were made were in the best interests of the person concerned. We did, however, find that the urgent authorisation for one person had expired and the home had not followed this up with the local authority. As such, any restrictions on this person's liberty would be unlawful. We raised this with the registered manager during our inspection. They assured us they would review their processes around DoLS applications to ensure applications were followed up in a timely manner.

Where people may display behaviour which challenged the service, we saw evidence in the care records that assessments and risk management plans were in place. These were detailed and meant staff had the information needed to recognise indicators that might trigger certain behaviour. Staff spoken with were aware of the individual plans and said they felt able to provide suitable care and support, whilst respecting people's dignity and protecting their rights.

Good

Is the service effective?

Our findings

Staff confirmed they had access to a structured training and development programme. This ensured people in their care were supported by a skilled and competent staff team. One staff member told us; “We’ve done a lot of training. There are about 20 sessions or so of E-Learning.” Another commented; “We could request and get any training we thought we needed on top of what is provided already.”

Staff training records showed staff had received training in safeguarding vulnerable adults, food safety, moving and handling, health and safety, medication, infection control, fire training and customer care. In addition there was a range of training taking place which reflected good care practices for people who lived at the home. This included staff development training on dementia, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Training was provided as a mix of practical training and E-Learning.

The people we spoke with gave us mixed messages about the food. Some people said; “It’s very good to say there are so many people. They come round the day before and you choose.”; “I get enough to eat and drink the food is OK.” Whilst other people commented; "I don’t like stews or cottage pie so I get something different. I don’t like the cooks chips they are soggy, so I asked her to get me some oven chips which she did.”; “I’m not too enamoured with the food. It’s always minced, you never get a slice of meat and I prefer my meat left and someone cut it up for me. It’s not as tasty as I would like.” A visiting relative told us; “There is a lot of cottage pie and hotpot which gets a bit boring. Yesterday it was meatballs or chicken pie and Mum didn’t want either. Mum loves the roast dinner on a Sunday.” We spoke to the registered manager about the comments raised. They told us that people's comments are constantly reviewed and where people wanted something different the cook would try to accommodate their preferences.

There was a choice of two hot meals provided at lunchtime on the day of our inspection. We observed the meal was well presented and looked and smelt appetising, although, the food that was provided was different to the menus that were on display in the dining room. We saw people were provided with the choice of where they wished to eat their meal. Some had chosen to eat in the dining room others in the lounge or their own room.

We observed lunch being served in a relaxed and unhurried manner. Tables were set with linen tablecloths. People were given the choice of what they wanted to eat or drink. We saw staff members were attentive to the needs of people who required assistance.

We spoke with the staff member responsible for the preparation of meals on the day of our visit. They confirmed they had information about special diets and personal preferences. They told us this information was updated if somebody’s dietary needs changed.

Staff at the home worked with people and their relatives to understand people’s likes and dislikes. Care plans reviewed detailed information about people’s food and drink preferences. Care plans also assessed people’s nutritional requirements. Assessments were monitored on a regular basis. Where there had been changes to a person’s care needs, care plans had been updated. We also saw appropriate referrals had been made to other health professionals, where there had been concerns about a person’s dietary intake. This confirmed procedures were in place to reduce the risk of poor nutrition and dehydration.

People’s healthcare needs were monitored as part of the care planning process. We noted people’s care plans contained clear information and guidance for staff on how best to monitor people’s health. For instance, we noted timely referrals to the dietician for people who were at risk of poor nutritional intake. The information received from the dietician had been translated into guidance in people’s care plans, for staff to follow.

Good

Is the service caring?

Our findings

During our inspection, we spoke with eleven people who lived in the home. We asked people about whether staff treated them well, whether staff were caring and whether their privacy and dignity was respected. People we spoke with all expressed their satisfaction with how caring the staff were. Comments included; " Yes, all of them are very good."; "I've no complaints, everyone is so kind, they can't do enough for you."; "They are very friendly and attentive"; "They knock and they call you by your first name which is nice." A relative we spoke with confirmed staff were always friendly and treated people with dignity and respect, they added; "If they are doing anything they always close the door." All of the people we spoke with told us staff took time to get to know their likes and dislikes.

We observed good practice where staff showed warmth and compassion in how they spoke to people who lived at the home. Staff were seen to be attentive and dealt with requests without delay. We also saw staff were very patient when accompanying people to transfer from one room to another. This showed concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety.

We looked in detail at five people's care records and other associated documentation. We saw evidence people had been involved with developing their care plans. This helped to demonstrate people were encouraged to express their views about how their care and support was delivered. A member of staff told us they had ready access to people's care plans, however, due to limited time, they were unable to spend time reading them. Staff did confirm that communication was good and that they were informed if there had been any changes in people's needs. The plans contained information about people's current needs as well as their wishes and preferences. We saw evidence to demonstrate people's care plans were reviewed with them and updated on a regular basis. This helped to ensure staff had up to date information about people's needs.

The service had policies in place in relation to privacy and dignity. We spoke with staff to check their understanding of how they treated people with dignity and respect. Staff gave examples of how they worked with the person, to get to know how they liked to be treated. One staff member told us, "We spend time talking with people to get to know them better and find out what they like."

During our observations we noted people's dignity was maintained. Staff were observed to knock on people's doors before entering and doors were closed when personal care was delivered.

There were a number of relatives visiting people during our inspection. We noted that staff respected people's privacy and did not interrupt people whilst they had visitors unless it was necessary. Relatives we spoke with confirmed they could visit any time they liked and were not aware of any restrictions on visiting their loved ones. We did observe that there seemed to be a shortage of seating for relatives who were visiting people in their rooms. We saw a number of relatives sitting on people's beds because there were not enough chairs available.

Requires Improvement

Is the service responsive?

Our findings

People were given information about the service in the form of leaflets and booklets. The information was illustrated with photographs and set out in an easy read style. There was a range of information leaflets on display in the reception for people who lived at the home and their visitors.

Throughout the assessment and care planning process, staff supported and encouraged people to express their views and wishes, to enable them to make informed choices and decisions about their care and support. People's capacity was considered under the Mental Capacity Act 2005 and we saw details of these assessments included in people's care records. Where specific decisions needed to be made about people's support and welfare; additional advice and support was sought. People were able to access advocacy services and information was available for people to access the service should they need to. This was important as it ensured the person's best interest was represented and they received support to make choices about their care.

People who lived at the home were allocated a named member of staff known as a key worker. This enabled staff to work on a one to one basis with them and meant they were familiar with people's needs and choices. We were told that as part of the care planning process, the key worker would review and discuss the person's care and support with them. Records we looked at showed these reviews did not always take place consistently. We did see from records that If people's needs changed, care plans were reassessed to make sure they received the care and support they required.

Records indicating people or their relatives were involved in the care planning process were inconsistent. Two out of the five records we looked at did not clearly show people or their families had been involved in regular reviews of the care provided. We asked people whether they had been asked for their opinions on the care they received. We received mixed responses which included; "No, not at all."; "No."; "I think they have residents meetings but I don't want to go." This showed people felt the service did not fully engage with them during the care planning and review process which meant the care delivered to people may not always meet their needs.

The home had recently implemented a new initiative called 'Resident of the Day'. The initiative was designed to help ensure people's holistic needs were met and reviewed on a regular basis. The resident of the day had their care plan reviewed with them, saw the hairdresser if they wished, would get to speak with the chef, maintenance team and receive some one to one time with the activities coordinator.

We looked at people's care records to see if their needs were assessed and consistently met. We found an example of good practice where following a fall at the home; staff had put a short term care plan in place for one person. The plan included a falls risk assessment, a body map to show any injuries suffered, a falls dairy and a plan of care to support the person. We also saw a referral had been made to the relevant health professionals for advice. This showed the home had responded to a person's changing care and support needs and sought timely medical advice as appropriate. However, we also found that one person had been admitted to the home and suffered several falls in a short time. The home's policy stated that risk assessment should be completed within 48 hours of someone being admitted. In this case, over a week later, we found that no risk assessments were included in this person's records. We also noted that the care plan for falls had not been implemented until after the first incident.

We spoke to the registered manager about their process for care planning when people are admitted to the home. They told us risk assessments should be completed within 48 hours of admission and full care plans within seven days. We told the registered manager about the files we had viewed. We explained that people's care needs should be assessed and recorded to ensure people receive appropriate care and support.

An activities coordinator was employed by the home to ensure that appropriate activities were available for people to participate in each day. During our inspection, we observed the activities coordinator leading sessions in the main lounge which included word games and quizzes. Most people seemed to enjoy the activities, but some people in the lounge declined to participate. We asked people what they thought about the activities that were provided. People told us about going out for walks, a recent trip to the botanical gardens and confirmed regular activities such as those we had observed in the lounge.

Requires Improvement

Is the service responsive?

Some people told us, however, that there was very little to do; “You sit around basically, there’s nothing to do here but sleep and eat.” Another resident said; “I stay in my room there’s nothing to do, I’ve been in the lounge once but I didn’t like it.” This person did not have any entertainment such as a radio or television in her room. We asked the activities coordinator what activities were provided for residents who preferred to stay in their rooms and they said; “I go into their rooms as soon as they arrive.” However the person we spoke with earlier told us they had been in the home for over a week but hadn’t yet been seen by the activities coordinator. A member of staff confirmed; “One to one time is supposed to be done for people who do not want to do group activities, but it’s not.” This meant where people did not want to participate in group activities, they may be at risk of becoming socially isolated. We fed this back to the registered manager who assured us they would look into it.

The service had a complaints procedure which was made available to people they supported and their family members. The registered manager told us the staff team worked very closely with people and their families and any comments were acted upon straight away before they became a concern or complaint.

Family members we spoke told us they were aware of how to make a complaint and felt confident these would be listened to and acted upon. One person said, “I would go to the manager, they listen to you and if they can sort it out they will do.”

Requires Improvement

Is the service well-led?

Our findings

We found the service had clear lines of responsibility and accountability. All the staff we spoke with were knowledgeable and dedicated to providing a high standard of care and support to people who lived at Rose Lodge.

The manager registered with the Care Quality Commission (CQC) in January 2012. A registered manager is a person who has registered with CQC to manage the service and shares the legal responsibility for meeting the requirements of the law, as does the provider. Staff spoke positively about the leadership of the registered manager.

A suite of audits was available to the registered manager to assist them in the on-going monitoring and assessment of the quality of the service provided at Rose Lodge. These covered a wide range which included care planning, medication and the environment. We looked at recent audits which were not consistently dated or signed by the individual that had completed them. There was also no action plan developed from the audits carried out. We looked at the most recent report from the monthly and six-monthly provider visits which were also used to monitor quality. We found shortfalls had been identified. However, no formal action plan had been developed to address the issues. This meant it was difficult to ascertain what progress had been made to resolve the issues highlighted by audits or by the provider visits. This showed that there were systems in place to regularly review and improve the service, but they were not being fully utilised.

The views of people were sought in various ways. For example through resident's meetings, relatives satisfaction surveys and regular care reviews with people and their family members. Although these systems were in place, they were not effective. We saw resident's meetings were held bi-monthly and any comments, suggestions or requests were fed back to the registered manager. This meant people who lived at the home were given as much choice and control as possible into how the service was run for them. However, we found that where people chose not to attend the meetings, they were not routinely approached for their opinions. We saw from the minutes of the resident's meetings that issues had been raised around the food provided and bathing/showering. People had raised a number of issues about the food and felt they were not receiving enough baths or showers. We were told by the registered manager that the menu was currently under review because of the issues raised by residents. This showed how people's opinions were sought and acted upon. However, issues around bathing/showering appeared again in the minutes from the following meeting. We could not find any evidence of action plans being drawn up to address this issue. People and staff we spoke with during the inspection highlighted bathing/showering as a problem, staff told us this was due to not having enough time. This showed that issues raised were not always addressed. Failing to have regard to complaints and comments made, and views expressed by people who use the service, in relation to the quality of the service provided, is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff spoke of a strong commitment to providing a good quality service for people who lived at the home. Staff confirmed they were supported by the manager and enjoyed their role. One staff member told us, "The manager is always approachable and will try and sort things out."

Staff attended handover meetings at the end of every shift and monthly staff meetings. This kept them informed of any developments or changes within the service. Staff told us their views were considered and responded to. Staff received regular supervision and appraisal, where they discussed their performance, development and any issues with the registered manager or deputy manager. This helped to ensure the staff team had support and any problems with performance could be addressed.

The provider had systems in place to identify, assess and manage risks to the health, safety and welfare of the people who lived at the home. Records reviewed showed the service had a range of quality assurance systems in place. These included health and safety audits, medication, staff training and supervisions as well as checks on infection control and housekeeping.

However systems to monitor the health, safety and well-being of people who lived at the home, had not been effective in identifying areas where people's safety was compromised. This included administration of medicines, risk assessment and care planning for new admissions, and ensuring adequate staffing levels to consistently meet people's needs.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Systems to monitor the health, safety and well-being of people who lived at the home, had not been effective in identifying areas where people's safety was compromised. The provider failed to have regard to complaints and comments made, and views expressed by people who use the service, in relation to the quality of the service provided.