Hillcrest Care Homes Limited

Roseway House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 28 November and 8 December 2016. This was an unannounced inspection. We last inspected the service on 28 September, 5 October and 19 November 2015 and found the provider had breached the regulations relating to medicines management and suitability of the premises.

Roseway House is a purpose built care home providing nursing and residential care for up to 49 older people, some of whom are living with dementia. At the time of our inspection there were 34 people using the service. In July 2016 a new provider took over management responsibility for the home.

Since our last inspection the home had a new registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following our last inspection the provider had made progress to improve the management of medicines in the home. We found there were accurate records to confirm medicines were administered and stored correctly. All of the high priority areas identified in the fire risk assessment had been actioned and completed since we last visited the home.

The current gas safety certificate and legionella assessment were overdue. These had been arranged and would be completed by the end of December 2016. We have asked the provider to confirm what action they plan to take to protect people from risks posed by uncovered radiators in the home. We are dealing with this issue outside of this inspection.

Relatives and care workers told us the home was safe. They also gave us positive feedback about their care and the care workers providing this care. Risk assessments had been carried out to help keep people safe. For example, people were assessed against the risk of poor nutrition, skin damage and falling.

Care workers had a good understanding of safeguarding and the whistle blowing procedure. They knew how to raise concerns and said they did not have concerns about people's safety. Safeguarding concerns had been dealt with in line with the agreed local procedures.

There were enough care workers to support people's needs in a timely manner. People and relatives told us care workers responded quickly to their requests for help. Care workers also said there were enough staff.

The provider had effective recruitment checks in place. These included requesting references and Disclosure and Barring Service (DBS) checks.

Incidents and accidents had been logged, fully investigated and action taken to help keep people safe from

harm.

Care workers were well supported in their role. One to one supervisions were on track following a period where opportunities for care workers to meet with their line manager had lapsed.

The provider followed the requirements of Mental Capacity Act 2005 (MCA). DoLS authorisations had been approved for all relevant people. Decisions made in people's best interests were only made following a MCA assessment. Care workers had a good understanding of the MCA and knew how to support people with decision making.

People received support in line with their needs. Personalised care plans described the support people needed with meeting their nutritional needs including their preferences and any special dietary requirements.

People received regular input from external health professionals when required. A visiting health professional gave us positive feedback about the care people received at the home.

People's needs had been assessed both before and after admission to the home. Not all people had a life history in their care records to help care workers better understand their needs. The registered manager said life histories and one page profiles were to be developed for each person.

Most care plans we viewed were personalised and included information about people's specific needs and preferences. Care plans had been evaluated regularly to keep them up to date.

Relatives gave us mixed views about the activities provided. In particular they commented that people living on the first floor did not always have opportunities to take part in activities. They also commented that people sat for long periods in front of the television. We also observed this on a number of occasions during the inspection. The registered manager advised a second activity co-ordinator was due to start and the activity programme was to be reviewed. Activities were on-going during our visit such as ball games. Other activities available included playing cards, chatting, watching TV and looking at memory cards. Some people were supported to do small daily living tasks. We have made a recommendation about the provision of activities.

Meetings for people and family members were being re-launched as these had previously been infrequent. A meeting was to take place on the evening of the day we inspected the home.

Relatives knew how to complain if they had concerns about their family member's care. Previous complaints received had been thoroughly investigated and resolved.

Relatives and care workers gave us positive feedback about the approachability of the registered manager. They also told us about the improvements made to the home, such as new flooring, the re-decoration programme, better support for care workers and improvements to the meals provided at the home.

We have asked the provider to send us the findings from the most recent consultation with people and relatives. This was not available when we inspected.

There was an effective quality assurance system in place. This included checks on medicines management, the quality of care plans and a nutritional audit. The audits had been successful in identifying areas for improvement and action had been taken to deliver these improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely.

Health and safety checks were up to date or planned in.

Care workers had a good understanding of safeguarding and the whistle blowing procedure, including how to raise concerns.

There were enough care workers to see to people's needs in a timely manner. Effective recruitment checks were completed before new care workers started their employment.

Incidents and accidents were dealt with effectively.

Is the service effective?

Good

The service was effective.

The frequency of supervisions had improved so care workers were now well supported in their role.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). Care workers knew how to support people with decision making.

People received support to meet their nutritional needs. They also had regular input from external health professionals when required.

Is the service caring?

Good

The service was caring.

People said they received good care and care workers were kind, considerate and caring.

People were treated with dignity and respect.

Care workers encouraged people to be as independent as

possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs had been assessed and personalised care plans developed.

Life histories and one page profiles were to be developed for each person.

The provision of activities in the home required further development so that all people had the opportunity to participate.

Relatives knew how to complain if they had concerns. Previous complaints had been dealt with thoroughly.

Is the service well-led?

Good

The service was well led.

Since our last inspection a new registered manager had been employed. Relatives and care workers told us the registered manager was approachable.

The home had undergone significant improvements to improve the quality of people's care and their environment.

The provider had asked relatives and people to give feedback about the home.

The provider had an effective quality assurance system to monitor the quality of people's care.

Roseway House

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 28 November and 8 December 2016. The first visit to the home was unannounced.

The inspection team was carried out by one adult social care 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.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Health Watch.

The provider completed a provider information return (PIR) prior to the inspection. 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 used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people who used the service and eight relatives. Most of the feedback we received was from relatives as many people using the service had difficulties with communication. We also spoke with the registered manager, the deputy manager, a nurse, a senior care worker and three care workers. We looked at a range of records which included the care records for four people, medicines records for 34 people and recruitment records for five care workers.

Good

Is the service safe?

Our findings

During our last inspection we found the provider had breached the regulations relating to medicines management and the suitability of the premises. This was because staff were not consistently recording the date medicines were opened. The home did not have a dedicated treatment room and did not always record fridge temperature checks to ensure medicines were stored correctly. Guidance about when to administer 'when required' medicines lacked sufficient detail. Some areas classed as 'high priority' identified during the last fire risk assessment were still outstanding at the time of the inspection. Evacuation and business continuity plans required updating as they contained some out of date information.

Following our inspection the provider sent us a report of the actions they planned to take to become compliant with these breaches. The actions included a review of all medicines protocols, a full audit of care plans regarding the administration of medication and monitoring the temperature of the treatment room and medicines fridge. The provider also confirmed all of the high priority areas identified in the fire risk assessment had been addressed. We found the provider had completed all of actions in line with the timescales set in the action plan.

Medicines records we viewed supported the safe administration of medicines. Records we viewed for the receipt, administration and disposal of medicines were accurate and complete. The provider had developed dedicated treatment rooms on each floor of the home to ensure medicines were stored appropriately. The temperatures of both rooms and the fridges used to store medicines were monitored to ensure they remained at an appropriate temperature. Only qualified nurses or senior care workers administered medicines to people. Records confirmed these staff had completed specific medicines training and had been assessed as competent. Where people had 'when required' medicines, personalised guidance had been written to ensure they received these medicines consistently and correctly. We checked the stock of medicines kept on the medicines trolleys. All opened medicines had a date of opening recorded on them to confirm they were still safe to administer.

Most health and safety checks were up to date. However, the current gas safety certificate and legionella assessment were overdue from when the previous provider was running the home. The provider confirmed these been arranged and would be completed by the end of December 2016. Other health and safety checks were up to date, such as fire safety checks, the electrical installation and portable appliance testing. We viewed the up to date fire risk assessment for the home and were shown confirmation that all actions identified had been completed. We noted that a potential safety issue regarding uncovered radiators in people's bedrooms had been identified. The maintenance man told us these radiators were exposed and became very hot, thereby posing a risk to people living in the home. The maintenance man told us the issue had been highlighted numerous times to the previous provider without any action having been taken. We have written to the new provider separately to confirm their plans for dealing with this issue.

The provider had up to date procedures for dealing with emergency situations. The business continuity plan covered various scenarios including loss of utilities, flooding and staff shortages. The plans clearly identified the required action to deal with each situation and who was responsible for taking the action.

People who live in the home were unable to give us their views about how safe they felt living at the home. Relatives and care workers felt the home was a safe place to live. One relative felt their family member was safe because of the precautions taken by the home. They gave an example of a mat placed by their family member's bed which alerted care workers when they got up. Another relative explained they chose the home because they felt "it's going to be really safe for her" and gave examples of the secure front door and keypad entry system.

Care workers also felt people were safe living in the home. One care worker told us, "They definitely are (safe), people are really well looked after. We have the right sort of equipment, the right sort of training. There are keypads on doors." Another care worker commented, "I think they (people) are very safe."

Care workers had a good understanding of safeguarding and knew how to raise concerns. We viewed the provider's safeguarding log which showed the appropriate action had been taken to deal with previous safeguarding concerns. This included referrals to the local safeguarding team and taking action to deal with any issues.

All of the care workers we spoke with were aware of the whistle blowing procedure. They said they had not needed to use the procedure but would not hesitate if they had concerns about people's safety. One care worker commented, "I would definitely raise concerns. Concerns would be dealt with." Another care worker told us, "I wouldn't be worried if I had to (use whistle blowing). The majority of staff really care."

The provider carried out a range of assessments to help protect people from potential risks. These included the risks associated with skin damage, poor nutrition and falling. Where specific risks to people's safety had been identified, a personalised risk assessment was carried to help minimise the risk of harm. For example, one person who lacked capacity was at risk because they regularly attempted to access the community without support. In practice we observed care workers carrying out support in line with people's needs. For example, using specialist equipment when supporting people to transfer from a wheelchair to a more comfortable chair. We saw they used the equipment correctly and always reassured people throughout the support.

People and relatives told us when they asked for help care workers responded very quickly and they never had to wait long. One person said care workers were "visible and available". One relative commented, "If I ask for help they come straight away." Other relatives told us they felt care workers weren't always available. Their comments included, "Sometimes they could do with another person", and "I think they could do with more". One relative expressed concern regarding the layout of a nursing unit and the impact this had when two staff were supporting people to shower. We discussed this feedback with the registered manager. They told us they had already been made aware of this issue by relatives and had taken action to improve communication so that people were never left unattended. We observed during our inspection people were usually supervised when spending time in the communal areas of the home.

Care workers consistently told us there were enough staff to ensure people received the care they needed. One care worker said, "(Staffing levels are) quite good. We can see to people's needs. I have no concerns." Another care worker commented, "We are okay with the staffing levels now." A third care worker told us, "We have enough staff, I feel we are part of a team." A fourth care worker said, "Staffing levels have improved."

Before new care workers started working at the home, a range of recruitment checks were carried out. We viewed the records for five recently recruited care workers. We found pre-employment checks had been completed to check new care workers were suitable to work with people using the service. This included requesting and receiving two references and Disclosure and Barring Service (DBS) checks. These checks

were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with people.

Incidents and accidents had been logged and fully investigated. Records confirmed action had been taken to keep help people safe following an incident such as reviewing risk assessments, treatment from the nurse on duty and additional monitoring to keep a check on people's wellbeing.

Good

Is the service effective?

Our findings

Relatives told us they felt care workers had the relevant skills and experience. One relative commented care workers were "knowledgeable and skilled". They gave us an example of how care workers assisted their family member to eat. Another relative said, "It's lovely, the lasses are good. They get well looked after".

Care workers were well supported in their role. One care worker told us, "I am very well supported. Since management changed I have managed to build up confidence." Another care worker said, "I feel quite supported. [Registered manager] is always checking if there is anything I need updating on training." A third care worker commented, "When I have asked for anything it has been provided." Earlier in the year supervisions had lapsed. However, records showed these were now back on track. For example, all care workers had received two supervisions and an appraisal between July and November 2016.

Records we viewed showed care workers had received the training they needed to meet the needs of people using the service. Essential training included moving and assisting, infection control, first aid and safeguarding. All care workers had completed specific equality, diversity and inclusion training. One care worker commented, "There are measures in place for training."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS authorisations were in place for all relevant people. We also saw examples within people's care records of MCA assessments and best interest decisions. For example, where people were receiving their medicines covertly, were unable to consent to their stay and for the use of lap belts on wheel chairs.

Care workers showed a good understanding of the MCA. One care worker commented, "We have to assume capacity, quite a lot lack capacity. On a day to day basis we still ask them, we still give choices and promote independence. Sometimes we have to make best interest decisions. We use care plans, to check what they prefer or family might have some input."

Care workers clearly understood the importance of empowering people to make as many of their own decisions and choices as possible. They told us about the strategies they used to support people with decision making. These include using menu cards for meal choices, explaining options to people and anticipating needs for some people by observing facial expressions and body language.

People's nutritional needs had been assessed. Care plans had been written to help ensure people received the support they needed with eating and drinking. The care plans we viewed were personalised to the needs of each person. For example, people's special dietary requirements, preferences and support needs were recorded. Relatives confirmed the meals provided at the home were good. They said the quality of the meals had improved since earlier in the year when there had been some complaints made. One relative said, "Overall it has improved" and "They've changed menus". As part of the home refurbishment plan the registered manager was planning to provide facilities to enable people and visitors to help themselves to refreshments.

Care records confirmed people had access to external health professionals when required. We spoke with a visiting health professional during our visit. They told us they felt people were "very well cared for". They went on to confirm the provider made appropriate referrals to their service and other professionals, such as dietitians.

Good

Is the service caring?

Our findings

People gave us positive views about their care. One person said, "It's a good place." Another person commented, "I like the staff." A third person told us, "They're good, they're all good. Everything's alright. I'm really happy here".

Relatives told us care workers were kind, considerate and caring. One relative told us, "They really care for [my relative]. They are very jolly, someone to have a bit of a laugh with. There's more than care, they definitely like them. It's more than just a job". Another relative said, "Staff are lovely, they're really nice." A third relative told us, "The staff are so nice. Most of them are really nice and I can talk to them about anything." A fourth relative commented, "They talk to her as if they've known her for years. They treat her like one of the family." A fifth relative said, "The staff are lovely, I couldn't fault them."

We observed care workers showed affection throughout their interactions with people. They were friendly, caring and warm in their conversations with people.

People were cared for by care workers who knew their needs well. One relative felt the care workers understood their relative's needs and responded accordingly. They described how care workers knew when their relative was tired and would encourage them to sit and relax. Other relatives told us care workers had got to know their relative well.

People were treated with dignity and respect. Relatives felt their family member's dignity and privacy were respected. One relative said, "I'm sure they do (show respect)." They gave an example of how care workers closed doors when their relative was being assisted with personal care. Another relative told us, "[My family member] is always clean and always tidy." A third family member commented, "They keep [my family member] nice and clean." A fourth family member told us, "They treat [my family member] really well." Care workers told us they actively promoted dignity and respect through ensuring people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, explaining what was happening and gaining consent first.

Care workers supported people to meet their choices and preferences. One relative said they were "over the moon" when care workers suggested they could help decorate and personalise their family member's room. They told us, "That personal touch makes such a difference. Just the thought that I could personalise it." They explained they appreciated care workers being proactive in making this suggestion.

People were supported to be as independent as possible. Care workers said they encouraged people to do as much for themselves as possible. One care worker told us, "We talk to them, encourage them to make their own decisions." Throughout our inspection we observed care workers encouraging people to participate in their support, such as when care workers supported people to mobilise.

Information was made available to people about independent advocacy. The provider also had a specific advocacy policy which included useful contact points for people such as local advocacy services.

Requires Improvement

Is the service responsive?

Our findings

Relatives said they felt involved in the care of their family member on a day to day basis and that they home kept them informed when anything happened. One person said, "They do get in touch". Another relative gave an example of how staff had responded positively to their requests to be informed about their family member (following an occasion when they hadn't been contacted). They confirmed following this they had been notified regularly.

People's needs had been assessed both before and after admission to the home. Care records contained some background information about people but these had not yet been consolidated into a usable format to guide care workers about people's needs. We also found that not all people had a life history. The registered manager told us they were planning to develop life histories and one page profiles for each person. These are important documents, particularly in relation to people living with dementia, to enable care workers to develop a better understanding of people's needs.

Most care plans we viewed were personalised with information about people's specific needs and preferences. For example, if people had preferred routines such as a particular bedtime or time for getting up, preferences for toiletries and food likes and dislikes. Care plans provided step by step guidance to help ensure people received consistent care and support. Some care plans were due to be reviewed and these care plans were not as person-centred as the newer care plans. Care plans had been reviewed regularly to keep them up to date with people's current needs.

Activity and engagement in the home required further development. We received mixed views about activities and engagement in the home. One relative said their relative was "just happy to sit and look about". Another relative told us, "They're a nice bunch of people. They sing with her and talk with her, they do interact with her." A third relative commented their family member "didn't have enough to do and was "sitting in front of the TV". A fourth family member said, "[My family member] spends their day in the chair facing the TV. They should have an activity coordinator upstairs." A fifth relative said they felt their family member's abilities had declined whilst being in the home and felt that there was insufficient stimulation. We observed there were occasions throughout our inspection when people were sat in communal lounges with little interaction from care workers. We fed this back to the registered manager as an area for further consideration.

The registered manager told us activities for people was an area that was evolving. A second activity coordinator had been recruited and was due to start their role in January 2016. The provider aspired to provide organised activities seven days a week. The structure of the activities programme was to be agreed when the second co-ordinator started. One care worker explained how the provider was moving towards a stance that activities are everybody's responsibility. They also commented that they felt most organised activities happened on the ground floor and that they would like more of a presence on the first floor. They hoped that when the additional activity coordinator was recruited that they would spend more time on the first floor. We fed this back for the provider to consider when deciding on the new activities programme.

Care workers gave us examples of things they did with people throughout the day. This included playing cards, chatting, watching TV and looking at memory cards. Some people were supported to do small daily living tasks such as wiping benches. We saw there were 'things to do' boxes throughout the home which included games and books. Relatives gave us examples of occasions when their family member had accessed activities in the local community. For example, care workers taking them out to the local shops, to the bingo and for a coffee. A care worker told us how they turned a trip to the nearby GP into an opportunity to look around the shops with one person.

Some activities were on-going when we visited. We observed a member of staff throwing a ball with one person. We observed some memory cards in front of one person but we did not initially see care workers interacting with the person in relation to the cards. Later a care worker used these cards to stimulate conversation with the person. We observed another care worker looking at a song book with two people but they did not sing the songs.

We recommend the provider considers current guidance on meaningful activity for people living with dementia and takes action to update their practice accordingly.

The registered manager told us resident and relative's meetings were being re-launched. Previously these had been infrequent and not well attended. We noted that on the day of our visit there was to be a relative's meeting that evening. One relative confirmed that they had received a letter inviting them.

Care workers told us they encouraged relative involvement. One care workers described the home as a "family orientated home". They went on to say, "We encourage families to get involved." They gave an example of how a family member had been involved with decorating the communal areas in the home.

All of the relatives we spoke with said they felt they would be able to complain to care workers or managers if necessary. We viewed the complaints log which showed there had been nine complaints received throughout 2016. Action had been taken to resolve the issues concerned. For example, there had been a number of concerns in early 2016 about the quality of meals provide at the home. In order to improve the quality of the meals the provider had provided additional training, on-going development for catering staff and improved the quality of the menus. Other complaints included concerns about the laundry provision and other isolated issues. All of which had been fully investigated and resolved.

Good

Is the service well-led?

Our findings

Since our last inspection the provider had employed a new registered manager for the home. We received positive feedback from relatives about the registered manager. One relative told us they knew who the manager was. They said, "I see [registered manager] most times I'm in". They added, "[Registered manager] listens to you and is quite approachable". Another relative commented, "[Registered manager] is generally about".

Care workers also told us the registered manager was approachable. One care worker said, "[Registered manager] is very approachable." Another care worker told us, "Management is brilliant, everyone gets on with the manager and deputy." A third care worker commented, "It is better now. [Registered manager] is fair to all staff and she is understanding as well." A fourth care worker said, "[Registered manager] is a good manager. I know I could go and talk with her."

Care workers were encouraged to give their views and make suggestions to improve people's care. One care worker commented, "[Registered manager] believes in encouraging ideas. So if we have any ideas she wants to hear them. She does listen."

There was a homely and welcoming atmosphere in the home. People and relatives were relaxed and comfortable in the home. They said they were made to feel welcome. Relatives had good relationships with staff and were on friendly terms with them. One relative told us, "I'm very happy with the place and very happy with the staff." Another relative said there was a "great atmosphere" in the home. A third relative commented, "The nurses are very approachable".

Relatives and care workers told us there had been significant improvements made since the current provider took over management of the home. One relative commented, "There has been lots of improvement in here." They gave examples of the flooring, painted doors and the re-decoration programme. One care worker told us, "Things are being acted on, there have been visual improvements. Staff support is completely different, food has improved a lot." Another care worker said, "It is much better because [registered manager] actually listens, she does what is best for the residents and for us. I have seen improvements in the level of care. She is open to implement any suggestions I have. I have all the support I need." We observed the home had undergone a major refurbishment programme which was drawing to a conclusion when we inspected. For example, the home had been redecorated throughout, new flooring had been laid and new furniture had been delivered. Soft furnishings were due to be delivered to add the finishing touches to the home.

The registered manager told us the current provider had consulted with people and relatives to assess their feelings about the home and the care provided. This feedback was not available when we inspected. We have asked the provider to send us this information when it is available.

The provider had a system of quality assurance checks in place to check people were receiving safe and appropriate care. These included checks on medicines management, the quality of care plans and a

nutritional audit. These had been effective in identifying areas for improvement and ensuring action was taken to promote sustained improvement. For example, the medicines audits were identifying a trend of gaps on MARs and not recording the date of opening on medicines. The provider had taken action including one to one training and development for particular care staff. We found the required improvements had been maintained as this was no longer identified as an issue when we inspected the home. The provider also consistently undertook a regular audit of the care provided at the home.

The registered manager carried out a monthly analysis of key information relating to people's wellbeing and safety. For example, keeping track of DoLs authorisations, skin integrity assessments, falls in the home and nutrition. It was evident from these checks that action had been taken to respond to changes in people's needs, such as referrals to dietitians and input from district nurses.