Oldercare (Haslemere) Limited

St Magnus Hospital & Rosemary Park Nursing Home

Inspection report

Marley Lane, Haslemere, GU27 3PX
Tel: 01428 647860
Website: www.rosemarypark.co.uk

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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?	Good
Is the service well-led?	Good

Overall summary

This was an announced inspection, which took place on the 4, 5 and 6 August 2015.

Rosemary Park nursing home provides accommodation and nursing care for up to 68 people who have various complex needs. It has three separate units within the same building.

The Main House is a 31-bedded mixed-sex unit for people with moderate to severe forms of dementing illness. During our visit, there were 30 people with one room out of commission because of maintenance work.

The East Wing is a 22-bedded single-sex unit for men with early or middle stages of a dementia type illness, or a longstanding mental health illness.

Summary of findings

The Courtyard is a 15-bedded mixed-sex unit for people with enduring mental health problems or acquired brain injury who cannot live independently.

The home had a 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.

All three units were clean, with good furnishings and were well maintained. Equipment was clean and in good working order. Staff did annual environmental risk assessments and acted on the results. Staff had safeguarding training in their annual mandatory training programme. They understood the forms of abuse and could apply that knowledge to people. Staff in all units managed medication well – including storing, documenting, administrating and disposing of it. The clinic rooms on all units had first aid kits and emergency resuscitation equipment. All staff knew which incidents to report and how to report them. Managers were available to staff for advice about which situations to report. Staff said they were confident in approaching any qualified staff or management for advice.

Each resident had care plans and risk assessments to guide staff in how to care for them. Nursing staff reviewed care plans every six months, with a shorter evaluation each month. Staff followed national guidance in managing and giving medicines and for managing dementia and other physical health conditions. The care team included a psychiatrist, activity coordinators, occupational therapist and social workers. There was good access to physical healthcare. The GP visited weekly and staff could see external healthcare providers including podiatry, chiropody, dieticians and nutritionists, speech and language support and a tissue viability nurse. Staff had formal supervision every eight weeks in line with the supervision policy, with informal supervision as needed. Managers held appraisals annually, with action plans for staff with extra development needs. There was a Mental Capacity Act policy and staff could tell us the principles and how they applied to their people. Each resident had a mental capacity assessment in place and additional assessments for specific interventions, such as medical procedures. Nursing staff recorded best interest decisions in people' notes and could explain what that meant.

Without exception, staff engaged with people respectfully, calmly and with a warm and friendly manner. They gave the right support when people were distressed or agitated, and always maintained their dignity. Staff understood not only the people' current needs but also their histories, likes, dislikes and daily routines.

People had personalised bedrooms, with photos and personal items. An activity programme ran through the week. The service had dedicated activity staff and all staff provided extra activities to stimulate people as well.

However;

Staff said although they felt otherwise well supported by managers, they did not feel well supported in dealing with harassment and bullying by people.

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 safe

Good

The service was clean, with furnishings in good condition. The clinic rooms on all units had first-aid kit and emergency resuscitation equipment.

Managers calculated staffing levels using a recognised staffing tool and these numbers were reflected on the units during our visit. The use of agency staff was minimal across the units.

People had risk assessments on admission and these were reviewed at the six-monthly full care review and after incidents and safeguarding concerns. Staff were aware of risks to people and had a good understanding of what they should do to keep people safe.

Staff had all received training about safeguarding as part of their annual mandatory training programme. They showed an in-depth knowledge of the forms of abuse and could apply that knowledge to individual people.

There was good management of medicines including storage, documentation, administration and disposal. people

Is the service effective?
The service was effective

Good

There was good access to physical healthcare. The GP visited weekly and there was access to other disciplines such as podiatrists, dieticians and speech and language therapists. Staff received training in tissue viability and were able to tell us about the importance of good skin management.

Staff received formal supervision on an eight weekly basis with informal supervision as and when required. Appraisals were undertaken annually with action plans created for staff who required a structure for additional development.

The units had a variety of rooms for people to use including quiet lounges and a designated room to use for visits. All units had access to gardens with seating areas

Food appeared appetising and attractive. Special effort had been made to make appealing meals for those requiring soft diets. Nutritional care plans documented the resident's likes and dislikes in addition to requirements such as low sugar or calcium rich diets.

There were Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures which staff followed.. Where relevant referrals were made to local authorities for DoLS.

Is the service caring?
The service was caring

Staff engaged with each resident in a respectful, calm, warm and friendly manner. They provided appropriate support when people became distressed or agitated, ensuring their dignity was maintained at all times.

Bedrooms were personalised with people's photos and personal items

Summary of findings

Staff demonstrated an in depth understanding not only of the resident's current needs but also of their histories, likes, dislikes and daily routines.

Where people had capacity, they were involved in the care planning process. We saw they had signed their care plans. Where people lacked capacity, relatives were involved (if people had relatives).

There was an advocacy service available to people and relatives.

One person had an advanced decision in place. This was reflected in their care plans. Do not resuscitate (DNR) decisions were documented in people' care records and staff were aware of their responsibilities regarding these.

Is the service responsive?
The service was responsive

Good

Care records showed an assessment of people's needs on admission including physical health assessment. Care plans addressed physical health in addition to mental health and wellbeing. Every resident had care plans to guide staff in how to care for them. This included a care plan specifically noting their dietary requirements, including likes and dislikes and the level of assistance required.

Bedrooms were personalised with people's photos and personal items.

There was an activity programme running throughout the week. There were dedicated activity staff and we saw staff engaging with additional activities to stimulate people in addition to this.

Representatives from different religions were available within the local area to come in and see people if desired. People attended a local church for services, with communion services at Rosemary Park each week.

Is the service well-led?
The service was well-led

Good

Each unit had a strong identity and awareness of their purpose. All staff were clear about the service they were providing for people and could describe the provider's core values being that of quality of life and high standards of individualised care.

Management were up to date with clinical audits, staff management and the management oversight of incidents.

Ward managers had the autonomy and authority to make decisions about changes to the service.

The staff survey showed staff felt supported by their line managers and felt they could safely raise concerns at work.

Staff told us they felt this was a good place to work; they felt supported and valued by the management.

St Magnus Hospital & Rosemary Park Nursing 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.

We visited the home on the 4, 5 and 6 August 2015. The inspection was announced and the team was comprised of two inspectors, a specialist advisor who was a mental health nurse specialising in the care of older people 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 looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to the CQC. A notification is information about important events which the service is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service did well and improvements they planned to make. The PIR was well completed and provided to us with information about how the provider ensured the home was safe, effective, caring, responsive and well-led.

During our inspection we spoke with three people who used the service, three relatives, three managers including the registered manager, a visiting GP and the safeguarding lead for the service. We visited the educational department and held focus groups with ancillary staff.

We observed care and support being provided by staff in communal areas and attended activities on all three units. We spoke with other staff members; including seven nurses, three care assistants, a student nurse and a social worker.

We collected feedback from 14 relatives using comment cards and looked at 16 people's care plans which included paperwork in relation to the Mental Health Act. We looked at 19 sets of care records across the units.

We checked the medicines management and observed staff administering medicines to people

We looked at various policies, procedures and other documents that related to how the service was run.

Good

Is the service safe?

Our findings

The building was an old manor house which had been extended and adapted to provide three individual units, Main House, East Wing and The Courtyard. The building presented challenges for observation of the people and staff managed this through individually risk assessed observation levels. People were encouraged to use the communal areas during the day where there was a member of staff present.

The courtyard and the main house were mixed-sex units and complied with national guidance.

The clinic rooms on all units were fully equipped with first-aid kit and emergency resuscitation equipment, which staff checked weekly.

We saw staff following good infection control practice including hand washing and managing soiled linen. Equipment was clean and in good working order. We saw evidence of maintenance checks in all equipment. In the main House, we found a hoist which had been decommissioned the previous day but not removed from the unit. It was in a bathroom that was used for people and did not have any notice instructing staff not to use it. We highlighted this to the manager and it was removed immediately. All units were clean, with good furnishings and were well maintained. The maintenance department went to the units daily and we saw staff actioned requests promptly. The units had dedicated housekeeping staff. Cleaning records were complete and up to date in all units. We also saw evidence of requests for a "deep clean" where it was needed. Environmental risk assessments were undertaken annually and we saw evidence of work being done as a result.

There were two care assistant vacancies on the main house unit; the other units were fully staffed. Staffing levels required for each unit was calculated using a recognised staffing tool and these numbers were reflected on the units during our visit.

The agency usage was minimal across the units. Managers were aware of the potential negative impact of unfamiliar staff providing care for people. Any required shift cover was managed through rotating staff across the units. If agency staff were required, they were preferably familiar with the people and were located on the main house as this was the unit where people had less complex needs who would be less anxious about seeing unfamiliar staff. Managers told us they were able to adjust staffing levels in response to the needs of the people across the units daily.

There were always staff on the communal areas of the units. However, during our visit to East wing the lounge was unobserved for short periods after lunch. While some staff were assisting people with personal care other staff had to attend to a person who had a fall in the adjoining dining area, which left the lounge briefly unobserved. We spoke to managers about this and they agreed to review the deployment of staff during the busy periods of the day as this was not an issue of low numbers of staff.

There was medical cover available. The GP visited every week and the consultants were available for support, advice and intervention when required.

Risk assessments were undertaken for all people on admission to the units. We saw evidence that reviews were undertaken during the six monthly full care review and following incidents and safeguarding concerns. They said they felt safe and that staff were friendly and genuine. All people were observed in line with their individual risk profile and we were told about occasions when observation levels were adjusted according to the resident's presentation.

Restraint was not used, staff told us this was due to people's ages and the range of physical disabilities which meant it would be unsafe to do so. Staff had all received training about safeguarding as part of their annual mandatory training programme and showed an in-depth knowledge of the forms of abuse and could apply that knowledge to individual people. Both unit staff and managers were able to describe their responsibilities in raising and documenting any safeguarding concerns and the process of investigation. Safeguarding alerts were made appropriately and procedures were followed according to policy.

There was good management of medicines across the units including storage, documentation, administration and disposal. Medication was dispensed at regular times by nursing staff. However, we witnessed an incident where nursing staff on East wing responded to a person who had

Good

Is the service safe?

a fall leaving dispensed medication unsupervised. This presented a risk of another person being able to take that medication which was not prescribed for them. We highlighted this to the unit manager at the time.

Staff were aware of the increased risk of falls with the people and could detail for us which people were at increased risk and how they manage that. We spoke with the management who recognised that falls were the most common incident reported for the units. They told us this was quite high but the risk had been balanced against the impact of over medicating people and the effect on their quality of life caused by increased levels of sedation. The GP agreed with the approach and we saw that staff managed risks well and people were kept safe.

The main house was adapted to facilitate safe movement around the ground floor for people with slopes and non-slip flooring. The East wing and Courtyard were purpose built extensions.

For people who were less mobile, there were tissue viability care plans in place and pressure sore risk assessments. Staff received training in tissue viability and could tell us about the importance of good skin management.

The clinical governance department gave information on adverse events to managers every month. The management team then discussed it and made changes as needed. We saw evidence of this feedback. There were no serious incidents recorded for these units in the last twelve months.

All staff knew which incidents to report and how to report them. Registered nurses completed the incident forms which they passed to management for investigation.

Managers were available to staff for discussion and advice about whether situations needed reporting. Staff we spoke to told us they were confident in approaching any of the qualified staff or management for advice.

Feedback from incident investigation was received from the clinical governance department following analysis and audit of the preceding month's forms. This was sent directly to all staff and the management team identified particular issues for discussion in team meetings.

We saw evidence of a change to policy for checking medicines prescriptions after an incident.

Good

Is the service effective?

Our findings

Care records showed an assessment of the people' needs on admission including physical health assessment. There were physical health care plans as well as mental health and wellbeing.

We saw evidence that staff followed national guidance on managing and giving medicines, and for dementia and other physical health conditions.

There was good access to physical healthcare. Some nurses on the units were dual registered nurses (those with both general and mental health qualifications) while the others were registered general nurses with a special interest and extra training in dementia. The GP visited weekly and there was access to other disciplines such as podiatrists, dieticians and speech and language therapists. There was input to the units from a range of medical professionals within the service including psychiatrists, activity co-ordinators, occupational therapists and social workers. External resources included podiatry, chiropody, dieticians and nutritionists, speech and language support and tissue viability nurses.

Handovers occurred on the change of shifts and included an update on each people' presentation and risks. We saw notes from handovers on each unit which evidenced this.

The units had a good working relationship with the social workers on site. Staff were aware of the social workers role and how that benefitted the people. We spoke with the GP who was visiting the units during our inspection who felt there was a good working relationship and staff responded well to people' needs.

Each person had a care plan specifically noting their dietary requirements, including likes and dislikes and the level of assistance required. We observed people being assisted to eat and drink and saw staff demonstrating knowledge of people's needs, encouraging their independence and following the care plans in relation to this accurately. We saw the food appeared appetising and attractive. Special effort had been made to make appealing meals for those requiring soft diets. People were able to have drinks and snacks throughout the day. Those with additional nutritional requirements had food and fluid charts to monitor their nutrition and hydration. Nutritional care plans documented people's likes and dislikes in addition to requirements such as low sugar or calcium rich diets. There were no people with cultural needs regarding food but the general manager was able to describe the requirements for a past resident of the Jewish faith. Records included nationally recognised rating scales such as the Waterlow scale and other nutritional health assessments, alongside, mental health rating tools for depression and capacity.

Staff were experienced and qualified to work with the people. They had undertaken specialised training in dementia and other relevant courses. Staff were supervised formally on an eight weekly basis with informal supervision as and when required. We reviewed the supervision record for the units and noted that all staff had received supervision in the last 3 months as per their policy. Appraisals were undertaken annually with action plans created for staff who required a structure for additional learning. Access to additional courses was reported to be excellent and readily available through the education and learning department. Managers on each unit told us they were available to staff for support and debrief should they need it. Staff confirmed this was the case and said they felt very supported after incidents, in particular following aggressive incidents.

Over 90% of staff had completed mandatory training. There were a few staff who were out of date with training and others were booked onto courses. The management were aware of these.

East wing and the Courtyard unit had appraisal rates for staff at 71%, the main house was slightly lower at 66%

There were two people under community treatment orders and one resident residing at the unit under section 17 of the Mental Health Act leave arrangements. We reviewed the paperwork and found it to be in order, and treatment plans were being followed.

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.

Good

Is the service effective?

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

Records showed that 84% of staff had undertaken Mental Capacity Act (MCA) training. There was a MCA policy in place and staff were able to tell us about the principles and how they applied to their people.

There were 35 Deprivation of Liberty Safeguard (DoLS) applications in the previous six months however there was a delay in DoLS assessments being undertaken by the local authority. At the time of our visit, there were over 40 assessments outstanding including some of which have been waiting to action for over a year. We reviewed the risk assessments for these people and found recognition of this and action plans for managing the people' risks until assessment is completed. The managers of each unit showed us evidence of contact with the local authority requesting assessments and highlighting this situation.

Each resident had a mental capacity assessment relating to care and treatment. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures. We witnessed staff practising the principles of the MCA during activities and over meal times, assisting people to make decisions about their meals and how or where they would like to eat. We saw documentation around best interest decisions in people' notes and staff were able to articulate what this meant. Adherence to the MCA and DoLS was monitored through the clinical governance department and the Mental Health Act administrator.

Good

Is the service caring?

Our findings

We conducted observations on each unit, including during meal times and activities. Without exception, the staff engaged with each resident in a respectful, calm, warm and friendly manner. They provided appropriate support when people became distressed or agitated, ensuring their dignity was maintained at all times. The people we spoke with were very happy on the units and felt supported and cared for by the staff Comment cards completed by relatives contained high praise for the staff; saying they felt their relatives were safe and happy. Some relatives told us the staff had made specific effort to get to understand their relative to be able to provide a high quality of life. Staff demonstrated an in depth understanding not only of the people' current needs but also of their histories, likes, dislikes and daily routines. We witnessed a member of staff helping people with complex needs have their lunch in an unhurried, relaxed and caring way. The staff member changed their approach with each resident to meet their individual needs.

Bedrooms were personalised with peoples' photos and personal items on show

Staff supported people to be involved in the planning of their care, and where people lacked capacity, their relatives were involved. Relatives who were involved in decisions about care and people we spoke with were extremely complimentary about the care provided.

There was an advocacy service available to people and relatives. Information was in the office and displayed on each unit and staff supported people to access the service.

One person had an advanced decision in place. This was reflected in their care plans. Do not resuscitate (DNR) decisions were documented in people's care records and staff were aware of their responsibilities regarding these. The care that was provided for people included end of life care.

The service focused on quality of life and personalised care. While helping people with drinks and meals, staff did so in a dignified, unhurried and respectful way. The units had a calm and peaceful atmosphere conducive to caring for people living with dementia. We particularly noted that this atmosphere did not change during busy times such as meal times or medication times.

Good

Is the service responsive?

Our findings

Total occupancy for the service has been an average of 96% for the year to end of March 2015. The service accepted admissions from St Magnus hospital on site or from care services across the UK. The general manager described the transfer of one person back to their home area so they could be nearer their family. People were only transferred between the units due to their changing health needs, for example increasing dependency and physical health care requirements or changes in the presentation of their conditions.

The units had a variety of rooms for people to use including quiet lounges and a designated room to use for visits. People in all units had access to gardens with seating areas.

There was an activity programme running throughout the week. There were dedicated activity staff and we saw staff engaging with additional activities to stimulate people in addition to this. At the weekends, staff arranged activities for individuals and / or small groups dependent on resident's needs. People told us that they enjoyed the activities programme, and looked forward to taking part.

We saw a sheet of translations in the file of a person who spoke limited English, both staff and relatives told us that the use of phrases in their first language helped the person feel more settled.

All people had care plans to guide staff in how to care for them. They were detailed and easy to follow. However, we found that they were not all as personalised as they could have been. We reviewed a range of care records across the unit and there was a clear difference in the level of personalisation where the relatives had been involved in the care planning process.

We saw staff had done a full review of care plans every six months with a shorter evaluation monthly. This included the risk assessments. Care records were paper based and stored securely in the unit's office.

A Holy Communion service happened weekly on the units, and this took place during our inspection. Representatives from different religions were available within the local area to come in and see people if desired. People who were able to attended a local church for services.

There had been one complaint in the last 12 months. This related to damage to a vehicle in the grounds of the unit. We tracked the complaint and found the policy had been followed accurately, and the complaint was upheld. No complaints had been referred to the ombudsman. Relatives told us they knew how to complain and felt confident their concerns would be addressed. Staff were informed of outcomes and lessons learnt from complaints through meetings, the communication book and individually if appropriate.

Staff showed an in-depth knowledge of the people and tailored their approach to meet individual needs and preferences. Staff took every opportunity to engage with people and joined in with spontaneous activities, with those who could not join in the arranged activity programme.

All three units held staff meetings and we saw minutes of these, however, they were not occurring regularly and staff confirmed this was the case. The team used the office communication book as a means of staying updated with important information about the unit and the people they cared for. We reviewed this and saw it was regularly used and contained a high level of detail. We saw minutes of staff meetings for the previous six months. These covered issues arising across all three units.

Good

Is the service well-led?

Our findings

All staff were clear about the service they were providing for people and were able to articulate the core values of the provider being that of quality of life and high standards of individualised care.

Staff knew the unit managers, general manager and the wider senior management team. They spoke highly of the support they received and felt part of the wider team. The senior management were visible on the units on a regular basis and the unit managers spent at least three days per week working as the nurse on charge of the shift to ensure they had clear knowledge of the challenges faced by their staff team.

Management were up to date with clinical audits, staff management and the management oversight of incidents. Unit managers told us they felt they had the autonomy and authority to make decisions about changes to the service. Audits were initially undertaken on the individual units by managers. The analysis and reporting on these was the responsibility of the clinical governance department. The findings were then communicated to staff and action plans devised to drive improvement where necessary.

Budget control was the responsibility of the general manager, with unit managers applying to them for any requests.

Relatives told us that the management team were very visible and were always available to speak with.

The most recent staff survey showed staff felt supported by their line managers and felt they could safely raise concerns at work. They felt there were adequate staff numbers and equipment to do their job. Sickness and absence rates were not available solely for this service but for the provider as a whole, the sickness rate on May 2015 of 1.27% which was good.

Staff were aware of the whistle blowing process and felt confident they could raise concerns to managers. There was a policy, which the provider would follow for the investigation of concerns.

Staff told us they felt this was a good place to work; they felt supported and valued by the management. They described the morale as being quite high despite the sometimes-difficult situations they had to deal with. The management on all units expressed their pride in the strong element of team working on their units.