Helen McArdle Care Limited

Roseberry Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service responsive?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 7 May 2015. Following the inspection the local authority received safeguarding concerns in relation to the care of people who used the service, staffs lack of understanding of positional changes when people were in bed and pressure area care. There were also concerns of inconsistency in care records such as positional charts, fluid balance charts and end of life care plans. The local authority shared the safeguarding concerns with the Care Quality Commission. We also received information of concern from a relative regarding the care and welfare of people who used the service and we shared this information with the local authority.

After receipt of the concerns there was a multidisciplinary team meeting chaired by the local authority to consider their serious concerns protocol and we attended this meeting. At this meeting the multidisciplinary team concluded that there were serious concerns about Roseberry Court. Other meetings were held to manage and monitor the serious concerns about the service. The registered provider developed an action plan detailing the steps they were to take to address the concerns. After the initial meeting the local authority made the decision to place a block on all new admissions and the registered provider agreed and complied with this, however, this was quickly lifted as the registered provider worked swiftly to make improvements. During this time representatives from the local authority visited the service to review people who used the service and to check for improvements. Following their visits representatives from the local authority gave us feedback and told us there was much improvement.

We undertook a focused inspection on 19 May 2016 to check the service had sustained improvement. This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting. At our inspection on 19 May 2016 we found that the registered provider had followed their plan and improvements had been made in all areas. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roseberry Court on our website at www.cqc.org.uk"

Roseberry Court provides care and accommodation to a maximum number of 63 people. Accommodation is provided over three floors. The ground floor of the home can accommodate a maximum number of 18 people who require personal care. The first floor of the home can accommodate a maximum number of 24 people who require personal care. The second floor can accommodate a maximum number of 21 people living with a dementia. Communal lounge and dining facilities were available within each unit. There is an enclosed garden/ patio area for people to use. At the time of our inspection there were 59 people who used the service.

The home had a registered manager in place. 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. The registered manager was on sick leave at the time of the inspection; however a registered manager from another home in the organisation was

managing the service on a day to day basis.

At the time of the inspection there wasn't any person who used the service who was nearing the end of their life; however we were shown a standard set of end of life documentation which was to be used by staff at the service. This included positioning charts, body mapping charts and food and fluid charts. The end of life plan had space to record information important to the person such as any wishes, a personal cleansing care plan and any relevant risk assessments. Management and staff told us how they regularly checked people's pressure areas and quickly reported any deterioration to district nurses. The end of life care plan was also to include a document called Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), this is a document that informs staff and other professionals not to make efforts to restart breathing and / or the heart in cases of respiratory / cardiac arrest.

We saw records which confirmed people's pressure areas were regularly checked and people's risk of developing pressure damage was regularly assessed. Staff spoke knowledgeably about providing pressure area care to people and told us they had received training, guidance and support from the management team. When people were identified at risk of developing pressure ulcers specialist pressure relieving mattresses were placed on their bed.

At the end of each shift senior staff did a handover report detailing important information on people who used the service. This now included new information or updates on those people identified at risk or who had any pressure damage to their skin. At the end of each day management checked the handover sheets and if there were any reports of redness to the skin or pressure ulcers they checked the persons care plan to make sure this had been updated.

Where needed, staff also kept a record of people's food and fluid intake and this included detailed information on the portion size people had eaten and how much fluid taken orally.

The registered provider has also reviewed their training in tissue viability, dying death and bereavement and end of life.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service responsive?

Good

The service was responsive

People received appropriate pressure area care. Staff were aware and understood the pressure area care for people who used the service and positional charts were completed.

Standard end of life documentation was in place to ensure consistency in care. Food and fluid charts were completed.

Roseberry Court

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 checked whether the registered 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 carried out a comprehensive inspection of this service on 7 May 2015. After the inspection we received information of concern and as a result we undertook a focussed inspection of the service on 19 May 2016. This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information we held about the service. The registered provider had previously completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were 59 people who used the service. We spoke with nine people who used the service and two relatives. We spent time in the communal areas and observed how staff interacted with people.

During the visit we spoke with the registered manager from another service, but who was providing support for the service, the senior lead and two care staff.

During the inspection we reviewed a range of records. This included five people's care records, including care planning documentation, positional charts, food and fluid charts, documentation to be used for those people who were at the end of their life, handover charts and other general records kept by staff relating to people who used the service.

Good

Is the service responsive?

Our findings

People who used the service and the two relatives we spoke with during the inspection spoke highly of the care and service provided. One person said, "I have been here for seven years and I am very happy. I can come and go as I please and the entertainment is very good." Another person said, "I get everything I need here. The food is smashing. I have just had a fishcake which was jolly nice." We spoke to one person about the pressure area care they received. They confirmed they were regularly hoisted during the day to alleviate pressure when they were sat in their wheelchair. They also told us, "I got a new pressure mattress on my bed last week which is comfy. I don't need help to move when I am in bed as I can move around myself." A relative we spoke with said, "I'm very satisfied."

The local authority received safeguarding concerns from relatives of people who used the service and visiting professionals. The Care Quality Commission also received information of concern about the care of people who used the service from a relative. Concerns were in relation to the staff's lack of understanding of positional changes when people were in bed and poor pressure area care. There were also concerns of inconsistency in care records such as positional charts, fluid balance charts and end of life care plans. Due to the serious concerns the Care Quality Commission attended multidisciplinary team meetings which were chaired by the local authority. The registered provider developed an action plan detailing the steps they were to take to address the concerns.

Representatives from the local authority visited the service on a number of occasions to investigate the concerns and to check for any improvement. The visits by representatives from the local authority identified the registered provider had worked swiftly to address the concerns and make improvement

We inspected Roseberry Court on 19 May 2016 to make sure the service has sustained improvement already identified by the local authority.

Management told us that as soon as they were made aware of the concerns a general staff meeting was arranged for the 1 March 2016. Due to the seriousness of the concerns the operations manager for the service had chaired the meeting. At this meeting staff were made aware of the safeguarding concerns and reminded of the whistleblowing policy and the actions to follow in reporting any concerns. Discussion also took place about the completion of positional charts, food and fluid charts, end of life care plans and processes to follow when a person is end of life. At this meeting staff confirmed they had received management support and guidance in completing all of the charts. Staff we spoke with confirmed they had attended this meeting.

During our inspection we looked at the care records of five people who used the service. At the time of the inspection there wasn't anybody who was nearing the end of life; however we were shown the standard set of end of life documentation which was to be used by staff at the service. This included positioning charts, management and staff told us how they would contact other professionals involved in the care of a person such as the district nurse and take advice on how often people should have their position changed. Food and fluid charts were also to be implemented until such a time the person was no longer voluntarily eating

and drinking and at this point mouth care would be provided at regular intervals and documented on the fluid charts. The end of life plan had space to record information important to the person such as any wishes, a personal cleansing care plan and any relevant risk assessments. Staff told us how they would regularly check a person for any redness or skin break down and record this on a body mapping chart and immediately contact the district nursing service for advice. The end of life care plan was also to include a document called Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), this this is a document that informs staff and other professionals not to make efforts to restart breathing and / or the heart in cases of respiratory / cardiac arrest.

The other care records we looked at were people who required positional changes to alleviate pressure to certain parts of their body and / or the completion food and fluid charts. Care plans were evident on file for those people identified at risk of pressure ulcers. People's risk in developing a pressure ulcer was also assessed by staff on a regular basis. Staff we spoke with during the inspection were aware of those people who were at risk of skin breakdown and showed us a file of all the positional charts for people on each of the units. We saw that positional charts had been fully completed and that there were no gaps. The registered provide used codes for different positional changes. There were a large amount of codes for different positions which staff told us were confusing. We saw there was some inconsistency in the different codes used by staff. We pointed this out to the management team who acknowledged the coding system could be confusing and that they would inform the head of elderly care to review the document.

Previously there had been some confusion about what staff understood as a positional change and how long the persons' position should be changed for. At this inspection we spoke with staff who were very clear about the different changes in a position, for example assisting the person to move from their left side to their back or to their right side and how often this should be performed. One staff member said, "I have been shown how to fill out all the charts and for the positional changes you alternate between the back, right and left side. We work closely with the district nurse who also gives us guidance."

Food and fluid charts had also been completed and this included the portion size people had eaten. We noted that on occasions staff had recorded the amount of fluid a person had taken on the positional charts but this had not been transferred over on to the fluid chart. We pointed this out to management on the day of the inspection who told us they had a care staff meeting arranged for that day and would share our findings with care staff so immediate improvement could be made. One staff member said, "We always record the actual fluid intake as cups can vary in size. We want to make sure we are accurate."

At the end of each shift senior staff did a handover report detailing important information on people who used the service. This now included new information or updates on those people identified at risk or who had any pressure damage to their skin. We saw how staff had quickly identified a deterioration in one person's pressure areas (who was already on two hourly positional changes) and contacted the district nurse to visit that day. At the end of each day management checked the handover sheets and if there were any reports of redness to the skin or pressure ulcers they checked the persons care plan to make sure this had been updated.

In addition to this there was a manager's monthly report which included the names of all people who used the service which enabled staff to see at a glance those people who needed positional changes and who were using specialist pressure relieving mattresses on their bed. We were told that there were a plentiful supply of different pressure relieving mattresses and if an alternative was needed this could be obtained within a 24 hour period. The manager's monthly report also identified if people were to have their food and fluid intake recorded.

The registered provider has also reviewed their training in tissue viability, dying death and bereavement and end of life.