Roseberry Care Centres UK Limited

Molescroft Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 16 April 2015 and was unannounced. We previously visited the service on 23 April 2013 and found that the registered provider met the regulations that we assessed.

The service is registered to provide personal care and accommodation for up to 44 older people, including people with a dementia related condition. The home is located in Molescroft which is close to Beverley, a town in the Riding of Yorkshire. It is on the outskirts of the town but close to transport links. There are three separate units: The House, The Annexe and The Haven. People are accommodated in single rooms and most have en-suite facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 24 February 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

We observed good interactions between people who lived at the home, staff and relatives on the day of the inspection. People told us that they felt staff really cared about them and that staff respected their privacy and dignity.

People were supported to make their own decisions and when they were unable to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home. Staff worked in one of the three units throughout their shift and this promoted consistency for people who lived in each unit.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed. Staff received a thorough induction programme before they worked unsupervised.

The laundry room was not fit for purpose; it was cluttered and was not divided into 'clean' and 'dirty' areas. The window frame was rotten and there were open pipes attached to the hot water boiler. It was not possible to ensure that the laundry room was maintained in a clean and hygienic condition.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People who used the service and relatives told us that staff were effective and skilled. Staff told us that they were happy with the training provided for them, and that they could request additional training if they felt they needed it.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that lessons were learned from any issues identified.

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?

Requires improvement

The service is not safe.

The communal areas of the home were clean, hygienic and well-maintained but the laundry room was not fit for purpose and did not promote good prevention and control of infection.

The arrangements in place for the management of medicines were robust and staff had received the appropriate training.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met, and that staff had been employed following robust recruitment practices.

Is the service effective?

Good

The service is effective.

People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they completed training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw and the other people we spoke with.

People's nutritional needs were assessed and met, and people's special diets were catered for. People told us that they liked the 'home made' meals they received.

People had access to health care professionals when required. Advice given by health care professionals was followed by staff to ensure that people's health care needs were fully met.

Is the service caring?

Good

The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Summary of findings

Is the service responsive?

Good

The service is responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities and people who were able were supported to see their relatives and friends and be part of the local community.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Good

The service is well led.

There was a registered manager in post at the time of the inspection.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

There was a cohesive staff team who told us they were well supported by the manager.

There were sufficient opportunities for people who lived at the home and others to express their views about the quality of the service provided.

Molescroft 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 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.

The inspection took place on 16 April 2015 and was unannounced. The inspection was carried out by an Adult Social Care (ASC) 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 who supported this inspection had experience of care services for older people.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information from health and social care

professionals. We did not ask the registered provider to submit a provider information return (PIR) prior to this inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we spoke with the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home. We also approached a number of social care professionals to request feedback and one person responded. On the day of the inspection we spoke with four people who lived at the home and chatted to others. We also spoke with two visitors / relatives, three members of staff, a visiting health care professional and the registered manager. A few days after the inspection we spoke with another relative to gain their views about the service provided by the home.

We looked at bedrooms (with people's permission) and communal areas of the home and also spent time looking at records. This included the care records for three people who lived at the home, the recruitment and training records for three members of staff and records relating to the management of the home, such as quality assurance and maintenance records.

Requires improvement

Is the service safe?

Our findings

We toured the premises to check on cleanliness and hygiene practices. We observed that people's bedrooms and communal areas of the home were clean and free from unpleasant odours. Someone we spoke with told us they had found their relative's bedroom and communal areas of the home to be clean, tidy and freshly painted, and that the bed and toilet in their relatives room was always clean. A health care professional told us that they had never had any concerns about hygiene practices or unpleasant odours at the home.

However, we checked the laundry room in The Annexe and saw it was not fit for purpose. It was not divided into 'clean' and 'dirty' areas. Clean laundry was hanging over the sink where soiled clothing was hand washed by staff. The window frame above the sink was rotten and there were open pipes attached to the hot water boiler. It was not possible to ensure that the laundry room was maintained in a clean and hygienic condition.

We also checked the laundry room in The Haven; this room was fitted with suitable equipment and was clean and hygienic. However, we again saw that clean laundry was hanging above the sink that staff used to hand wash soiled clothing. The room was small and it was not divided into 'dirty' and 'clean' areas.

There were cleaning schedules for beds and pressure relieving equipment and all areas of the home. Most chairs and headboards were made of wipeable material so they were easy to keep clean. However, the registered manager said that some people had brought their own beds into the home so there were a few fabric headboards in people's bedrooms. The manager told us that she would address this with the people concerned.

We saw that there was hand disinfecting gel, paper towels and personal protective equipment (PPE) available in various areas of the home so that it was easily accessible to staff. However, in The Haven there was no-where for staff to wash their hands.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We spoke with four people who lived at the home and they told us they felt safe living at Molescroft Court. One person told us, "Yes, I have call buttons to get staff" and another said, "Yes, because everyone is friendly and you are never afraid." This was supported by the relatives who we spoke with. One relative told us, "The room is safe and the home is safe."

We saw that staff induction training included information about safeguarding vulnerable adults from abuse and the training record evidenced that all staff apart from two had completed additional training. Staff were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff also told us that they had to make clear records of any incidents that occurred.

We spoke with the local authority safeguarding adult's team prior to the inspection and they told us they did not have any concerns about this service. We saw that when the registered manager had submitted a safeguarding alert to the local authority, a copy of the alert was held in the person's care plan so that all staff were aware that an alert had been submitted. A social care professional told us that staff always contacted them to discuss any concerns or safeguarding issues; this indicated that staff understood their responsibilities in respect of safeguarding vulnerable people from abuse.

Staff told us that they understood the organisations whistle blowing policy and that they felt information they shared with the registered manager or a senior member of staff would be dealt with confidentially and that they would be listened to.

Although people had individual dependency assessments in place, the registered manager told us that they did not use a dependency tool to determine staffing levels. She said that they were currently staffed over the standard staffing levels and this meant there was usually someone to cover staff absences and that there were sufficient numbers of staff on duty to meet people's assessed needs.

The standard staffing levels were two care workers per unit throughout the day; this consisted of a care worker and a senior care worker or team leader. The service aimed to have five staff on duty overnight but on occasions there were four staff on duty. This allowed for there to be one member of staff in each unit and one member of staff to

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work between the units to support any occasions when two staff were needed to assist someone with transfers or mobilising. People told us that there were sufficient numbers of staff on duty during the day but some people mentioned that staff were less visible during the night. However, no-one who we spoke with felt that this had affected their care. One person told us, "To be honest sometimes staff say they are short, but it hasn't affected me."

We asked relatives if they thought there were sufficient numbers of staff on duty. One person told us, "No – when I ask if (my relative) has been out of their room I am told they haven't, because there are not enough staff. They also don't get enough baths." However, another relative told us that they had always observed that there were sufficient numbers of staff around the home, including at meal times. We spoke with a health care professional on the day of the inspection. They told us that staff were always available to assist them when they visited the home.

The registered manager worked supernumerary to the staff recorded on the rotas. In addition to this, there were 33 hours dedicated to a person who needed one to one support. On the day of the inspection we observed there were sufficient numbers of staff on duty to provide care and support for the people who lived at the home. We checked the staff rotas and saw that these staffing levels had been consistently maintained. Staff told us that the registered manager or senior staff always tried to cover staff absences so that there were always enough staff on duty to meet the needs of people who lived at the home.

We saw that ancillary staff were employed in addition to care staff; this consisted of cooks, kitchen assistants, domestic assistants, laundry assistants, an administrator and a full-time handyman. The registered manager was in the process of recruiting an activities coordinator to work 30 hours a week. This meant that care staff were able to concentrate on supporting and caring for the people who lived at the home.

We noted that staff toilet facilities were only available in one unit. This meant that, during the night, staff had to leave the unit where they were working to use the toilet. We were concerned that this could have left a unit without a member of staff for short periods of time during the night and that people's safety could be compromised. We asked how staff communicated with each other during the night and were told that they had been provided with mobile telephones. In the past they had used walkie-talkies but these had proved to be unreliable.

We saw that risk assessments were included in people's care plans. Everyone had risk assessments in place in respect of mobility, pressure area care and nutrition. In addition to this, people had individual risk assessments in place for topics such as leaving the premises, poor hand hygiene and use of the garden. We saw that risk assessments were reviewed regularly and contained information to advise staff on how to reduce any identified risks.

People also had risk assessments in place when it had been identified that they were at high risk of having a fall. We saw that one person's care plan recorded that a sensor alarm was being used to alert staff to when the person got out of bed; this was to reduce the risk of falls.

There were management plans in place that included details of any triggers to people's behaviours. One person's care plan included the heading "Triggers which will upset me and may cause aggression and frustration." The details recorded were, "Being told I can't do something. This makes me feel like a child and useless. I need staff to use distraction techniques with me." The information went on to record the kinds of topics that the person likes to discuss that would distract them from their feelings of frustration. This information helped staff to understand how to manage people's behaviour.

As well as an overall record of accidents and incidents that had occurred at the home, there was an individual record in each person's care plan; these also recorded any falls that the person had. The form recorded the number of falls, the area where the person had fallen, the time of day, any changes in medication or infection, whether a referral had been made to a health care professional and any other action taken. When accidents or falls had occurred, any injuries were recorded on a body map; this helped staff to monitor the person's recovery. Accidents, incidents and falls were analysed to check whether any patterns were emerging or if any corrective action needed to be taken.

We checked the recruitment records for three new members of staff. We saw that application forms had been completed and that they recorded the person's employment history, the names of two employment

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referees and a declaration about whether or not they had criminal convictions. Prior to the person commencing work at the home, checks had been undertaken to ensure that people were suitable to work with vulnerable people, such as references, a Disclosure and Barring Service (DBS) first check, a DBS check and identification documents. We saw that a thorough interview had taken place to explore a person's suitability for the role they had applied for and that interview questions and responses had been retained. Staff also received a copy of the staff handbook when new in post. Staff confirmed that they had been through a thorough recruitment process when they applied for a post at the home.

The senior member of staff on each unit was responsible for the administration of medication. Each unit had a medication trolley and we saw that these were stored securely. We saw that the temperature of the medication fridge and medication room was taken regularly and that temperatures were consistently within recommended guidelines. This ensured that medicines were stored at the correct temperature.

Controlled drugs (CD's) were stored in a CD cabinet in the medication room in the main building. Two different senior staff members held keys to the CD cabinet and both keys were needed to access the cabinet; this enhanced the security of medicines stored in the CD cabinet. We checked a sample of controlled drugs and saw that the records in the CD book matched the number of medicines in the CD cabinet. We also checked the records of returned medication and found these to be satisfactory.

We checked the content of one medication trolley; we saw that blister packs were colour coded to identify which time of day the medicine should be administered. Packaging on creams and liquids recorded the date that staff started to use the medicine as that may have been a different date to the date it was supplied. This made sure that medicines were not used for longer than the recommended timescale. We observed a member of senior staff administering medication on the day of the inspection and noted that they carried out this task safely; they did not sign medication administration record (MAR) charts until they had seen the person take their medication. The medication trolley was locked when unattended.

We checked MAR charts and saw that they included the person's photograph; this is useful for assisting new staff with identification. MAR charts also included the name of the person's GP, any known allergies, their room number and personal comments. One person's MAR recorded, "No assistance required – will choose daily what she would like and when" and another recorded, "Take medication with a glass of water please." Two staff had signed hand written entries to confirm that they were correct and reduce the risk of errors occurring. We saw one gap in recording; this was for a food supplement rather than a medicine.

Staff completed a medication handover sheet and both senior staff signed the sheet when it was handed over from one shift to the next. We saw that the sheet recorded, "Please be mindful of pain relief dosage – 1 or 2 to be marked on MAR charts." We saw that codes to record when people had not taken medication were used appropriately and that staff had recorded whether one or two tablets had been administered for 'as and when required' (PRN) medication.

Staff told us that they did not hold stock medication apart from pain relief medication. They only ordered the medication they required for the month. There was an audit trail for prescriptions so that staff could check that the medication prescribed by the GP was the same as the medication supplied by the pharmacist. The pharmacist supplied a separate chart to record the administration of creams and pain relief patches. This recorded the area of the body where the cream or patch should be applied.

The staff members who were responsible for administration of medication had completed appropriate training. We saw that medication systems at the home were audited on a regular basis; audits included checks on controlled drugs, self-administration and staff competency. We saw that the pharmacy that supplied the home with medication had carried out an advice visit in February 2015.

Some of the people who we spoke with were able to explain what their medication had been prescribed for and all of the people we spoke with told us that they received their medication on time.

There was a contingency plan in place to advise staff how to manage emergency situations and this included a personal emergency evacuation plan (PEEP) for each person who lived at the home. The documents

Requires improvement

Is the service safe?

appertaining to each unit were stored in a red box that was placed close to the main door of the unit for ease of access. A copy of each person's PEEP was also held in their care plan.

We asked staff to describe how they kept people safe. One member of staff told us, "We keep the home clean and tidy and hazard free."

We found that the premises were well maintained to ensure the safety of people who lived at the home. We saw there was a current gas safety certificate in place and we saw evidence that lifts and hoists had been serviced. There was a fire risk assessment in place. The handyman carried out in-house tests of the fire alarm system, bed rails, window opening restrictors, moving and handling equipment and the call system. We saw that these checks had been carried out consistently.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. We saw that care plans included a DoLS screening checklist and discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS.

The training matrix recorded that only two staff had undertaken training on the topic of MCA and DoLS. We asked staff about their understanding of MCA and DoLS. One person told us that they had received training and another said that these details were in people's care plans. They added, "We are not allowed to use restraints."

When people had the capacity to consent to their care and treatment and to their admission to the home, they had signed a document to evidence this. One care plan that we saw recorded a best interest meeting had been held to decide where the person should be cared for. The decision was that they needed residential care as this was the "Least restrictive option." Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

We saw that each care plan had a record of the person's capacity to make decisions in an "Assessment of decision making" form. One person's care plan recorded, "Please ensure my opinion is asked for in all aspects of my care. If I am unable to make a choice / decision I would like staff to act in my best interests, taking into account my previous likes and dislikes." Relatives told us that they were involved in decision making when people lacked the capacity to make their own decisions. One relative told us, "They do contact me if any decisions are to be made."

We asked people if they had choice and control over their care. One person told us, "I'm definitely in control over what is going on" and another said, "I think I am in control. They don't force me with anything." A third person told us, "I have choices over bedtimes and where I spend my day." Staff told us that they gave people choice, autonomy and control over their care whenever this was possible. One member of staff said, "We give them choices about food, ask them, give them choices about all things "and another said, "Everything is explained to residents."

The registered manager told us that thirteen people who lived at the home had a diagnosis of a type of dementia. One member of staff had undertaken training with Bradford University on dementia care. This training enabled the staff member to facilitate training on personalised dementia care to the rest of the staff group. The dementia 'lead' in the team had undertaken training via Sterling University; this provided helpful advice about suitable environments for people living with dementia.

We saw that doors had been painted in different colours to assist people to identify toilets, bathrooms and their bedroom. There were signs around the home to make it easier for people to find their way around. One person had a particular animal that they were fond of and staff had placed symbols using this animal to guide the person to and from their bedroom; this was done discreetly and looked like part of the general decor. A relative who we spoke with told us that they thought the premises were suitable for people living with dementia.

The premises were also suitable for people with reduced mobility; there were ramps to entrances to the home and a passenger lift to the first floor. We asked people if they were able to move around the home easily. One person told us, "Yes, I have an electric wheelchair and its fine."

However, we noted that the dining room in The Annexe would be better situated elsewhere in the home. Staff had made it look as pleasant and inviting as they could, but the dining room was in effect a wide corridor, with flooring suitable for a corridor and no curtains or blinds at the windows. People told us that this area became too hot to use in the summer months. We also noted that the main entrance to the premises was difficult to locate, did not look welcoming to people and was next door to someone's bedroom. We discussed with the manager how these areas should be considered as part of the home's refurbishment programme.

A visiting health care professional told us, "Rooms are personalised. Communication is very good. If staff have any problems they ring for advice and my advice is listened to 100%."

Good

Is the service effective?

We asked people who lived at the home about communication with staff. They told us, "Staff are always chatting to me and telling me things", "They are friendly and they talk to me" and "Some will sit and talk to me." However, another person said, "They don't have a lot of time (to talk)."

We saw that staff completed a thorough induction programme whether or not they had previously worked in a care setting. Staff who we spoke with told us they had undertaken induction training that included shadowing experienced staff and looking at the organisation's policies and procedures. They said their induction training also included the topics of moving and handling, the use of hoists, basic care skills, dignity, respect and fire safety. One member of staff told us, "I was given a training booklet to work through and I worked through all of the different units."

We checked the training matrix (record) and saw that this recorded whether training courses had to be completed every six months, annually or every three years. We saw that all staff had completed training on fire safety although one person was overdue for refresher training. Almost all staff had completed training on food hygiene, moving and handling, health and safety, infection control, nutrition, the control of substances hazardous to health (COSHH), first aid and safeguarding vulnerable adults from abuse. Some bank staff had not completed these courses and some staff were booked on courses.

In addition to attending training courses, 19 care staff had completed a National Vocational Qualification (NVQ) or equivalent at either Level 2 or 3 in Care. A further eight staff were working towards a NVQ or equivalent award. This showed that staff who wanted to further develop their knowledge and skills were supported by the organisation to do so.

Relatives and people who lived at the home told us that staff had the skills to carry out their roles and had the right approach. One person who lived at the home said, "Yes, they do – no trouble with them", another said, "Some are very caring – some are better than others" and a third person told us, "They do care. We have a laugh together and a bit of banter."

There was a staff supervision matrix in place; this recorded that the registered manager, three team leaders, the head cook and the head housekeeper had a team of staff who they met with for supervision. There was a good record of topics discussed and this included training to be carried out before the next meeting. Staff who we spoke with told us they had regular supervision. One staff member said, "I speak to my team leader. I feel supported – she helps me out a lot – and the manager does as well" and another told us, "If I've got an issue or I'm upset, I'd speak to the manager or my team leader. All are approachable."

People told us that there was a choice of meals available and that they were generally satisfied with the quality and choice of food provided. Care plans recorded people's likes and dislikes regarding food and drink. One person told us, "I don't like boiled eggs and they know this." Care plans also recorded any risk of dehydration or malnutrition and appropriate assessments and risk assessments had been carried out. One person's care plan recorded, "I am diabetic. I need to gain weight. To weigh weekly and encourage snacks as need to maintain weight due to walking all day." Another person's care plan recorded, "I like soft foods."

When people had been identified as being at risk of malnutrition or dehydration, food and fluid charts were being used to monitor their daily food and fluid intake. We saw that liquids were measured in millilitres (mls) so there was an accurate record of fluid intake. We saw in care plans that dieticians and other health care professionals had been consulted when people were considered to be at risk of malnutrition of had swallowing difficulties. Any advice given had been incorporated into care plans.

We spoke with the cook; they told us that when someone moved into the home they filled in a chart to record their likes and dislikes, any allergies and any medical conditions such as diabetes. This happened for people who were moving into the home permanently and people who were having respite care at the home. Staff who we spoke with were also able to describe people's special dietary needs.

The cook said that people could have a cooked breakfast any day of the week, and there were two choices on the menu every lunchtime and tea-time. People could have an alternative if they did not like either of the choices on offer, and they would buy things especially for people if they requested it. All food was home cooked including pies, scotch eggs, fish cakes and cakes; the only food 'bought in' was bread and only quality products were purchased. We

were told that five people had liquidised diets, two people required a soft diet and one person was diabetic. This person had the same meals prepared for them as everyone else but sugar was replaced with 'low' sugar for their meals.

We observed the serving of lunch and saw that it was an enjoyable experience for people and that they were served with freshly cooked appetising food. We saw that tables were set with table mats and condiments to make the dining areas look as welcoming as possible.

There was a menu on display and this included pictures as well as a written description of the meal choices. In The Haven we saw that people were not offered an apron to protect their clothing and that one person had a meal taken to their room and they had not attempted to eat it. We were concerned that, by the time a member of staff arrived to assist them to eat their meal, it would have been cold. In the other units we saw that people were encouraged to eat their meals and that people were appropriately assisted to eat their lunch.

We saw that plenty of drinks were offered throughout the day and that people could also ask for a drink at any time. People who were not inclined to drink were encouraged by staff to do so.

The home had been awarded a score of five in respect of food hygiene by the local authority. This is the highest score available.

People's health conditions had been recorded in their care plan and any contact people had with health care professionals had also been recorded. These records included the date, the name of the health care professional, the outcome of the visit and a staff signature. We saw that any advice given by health care professionals had been incorporated into care plans to ensure that staff had up to date information to follow.

We asked people if they were able to see their GP when they needed to. People told us that they had no concerns about their access to health care professionals. One person said, "I can get a doctor – I had a doctor last week. The district nurse is coming today as well." Staff told us that they would not hesitate to ring a GP if they thought someone was unwell.

People had been assessed to determine whether they needed any equipment to promote good tissue viability and we saw that this equipment had been provided when needed, such as pressure care mattresses and cushions. Any pressure areas or other marks noted by staff had been recorded on a body map to assist staff with monitoring the person's skin integrity.

Good

Is the service caring?

Our findings

We observed that there was positive and friendly interaction between people who lived at the home and staff throughout the day. People told us that staff really cared about them. One person told us, "I feel they really care about me." A social care professional told us, "I have noticed on my visits that the carers are very caring in their role and do their best to provide a person-centred approach and well-being." A visiting health care professional told us that staff worked well as a team and "Really cared and were compassionate" about the people who lived at the home.

Relatives told us that staff cared about people they were supporting. One person told us, I think they do care. I have seen staff with him and they are good" and another relative said, "Yes, some care a lot more – they have a laugh with her." A member of staff told us, "Staff have a laugh with residents. A lot of the staff have been here a long time and they really know the residents."

We saw that people looked well dressed and cared for. Care plans included information that advised staff how people liked to be assisted with personal care. There was a record of the tasks that people would need assistance with, how many staff would be required to provide this support and the level of risk involved.

We saw that people were treated with dignity by staff and that their privacy was promoted. We observed staff knocking on doors before entering. We also saw the person administering medication discreetly asked people about their need to take 'as and when required' (PRN) medication. We asked people if they felt their dignity and privacy was respected. One person told us, "Nothing they do bothers me" and another person said, "From my experience, yes." We asked staff how they protected people's dignity. One staff member told us, "I ask if they need help. I shut the curtains, close the doors and put towels over them." Another member of staff told us, "Take them up to their room if say a doctor visits."

We observed on the day of the inspection that people's independence was promoted and that they were encouraged to do as much for themselves as they could. A relative told us, "They assist her at bath times but they let her wash herself." A member of staff told us, "Depending on the resident – I know some people need more assistance with personal care. I try to let them keep their independence" and another said, "Encourage them to do as much as they can themselves. You know your residents and what they can do."

We asked people who we spoke with if they were kept informed about what was happening at the home. One person said, "I don't think so, but I got told about the new manager last year" and another person told us, "We get to know, but not especially." However, people told us that the registered manager was approachable and they could talk to her. One person said, "I can talk to her. She tells me it should feel like home from home." The minutes of 'residents' meetings and other information we saw indicated that people were kept up to date with events at the home, and about matters that affected their own health and well-being.

Visitors told us that they were kept informed of their relative's well-being. One relative told us that the home had called the GP and they had received a telephone call to explain the reasons why the GP had been contacted. Other relatives told us, "Yes I am, they keep me informed" and "He'd tell me himself but if it was serious they would contact me" This information was recorded in care plans in the relatives communication record.

We asked the registered manager and staff about handover sheets and we were told that each person who lived at the home was discussed at every handover meeting. This included information about food and fluid intake, sleep pattern, pain relief and assistance with personal care. Staff told us that they recorded information about people to make sure all staff were aware of the person's current situation. One member of staff told us, "I read the care plan and also put things in the diary for all staff to see."

We saw that a person's care plan recorded their wishes for end of life care when this had been discussed with them. We saw that appropriate pressure care equipment had been obtained for people who remained in bed or spent long times of the day in bed. People were also repositioned regularly to alleviate the risk of pressure sores developing and hydration was encouraged; these inputs from staff were recorded appropriately. In addition to this, regular checks were made of people's skin integrity and any sore areas were recorded on a body map. The 'Abbey' pain scale was being used to measure people's pain level when they were unable to express this verbally.

Good

Is the service caring?

Approximately 50% of staff had received training on end of life care. This meant that staff had some knowledge about how to care for people sensitively and effectively when they were at the end of their life.

Good

Is the service responsive?

Our findings

We checked the care records for three people who lived at the home. There was evidence that people had been involved in developing their care plans. One person's records stated, "I have been consulted about my needs, wishes and preferences and have been fully involved in the writing of this plan of care." One person who we spoke with said, "They have got it (a care plan) somewhere. We went through it together. I think it was revised last year." However, the other people we spoke with were not sure whether they had seen their care plan. A relative told us, "I think she has (had input into her care plan) – I've had nothing to do with it." This indicated that when people had the ability to contribute to their own assessments and care plans, they were invited to do so.

We spoke with someone whose relative had stayed at Molescroft Court for respite care. They told us that they would be quite happy for their relative to have respite at the home again. They said that they were made welcome at the home; they could visit at any time and staff had helped them to take their relative out for a short while. In addition to this, on a couple of occasions they had stayed for lunch with their relative and they felt that this had enabled them to spend quality time with them.

Care needs assessments had been completed prior to the person's admission to the home. Areas assessed included communicating, eating and drinking, mobilising and sleeping. There were also details of people's known health conditions and we noted that this information had been updated if any further health conditions had been diagnosed. The information gathered during the assessment had been used to develop an individual plan of care.

We saw that care plans were based on the individual needs of the person concerned. They included a document called "This is me" that had been produced by the Alzheimer's society. This document included information about the person's life history and previous lifestyle, such as their family relationships, previous employment and their likes and dislikes. This gave staff more knowledge of the person's life prior to their admission to the home and helped them to build relationships with people and to meet their individual needs and preferences. Personalised information was recorded such as, "I am a very private person" and "I love having a bath weekly with lots of bubbles and a drop of brandy." We asked people who lived at the home if they felt their care was centred around them and they all responded positively, and this view was supported by relatives who we spoke with. Staff told us that they read people's care plans and this helped them to understand people's individual needs.

We saw that assessments, risk assessments and care plans were evaluated each month and that any changes made to the care plan were signed and dated so that it was clear when any changes had occurred and that staff had up to date records to follow. More formal reviews were held to check that people were receiving the care they needed and wanted. People who lived at the home and relatives told us that they were involved in these reviews.

There was a vacancy for an activities coordinator and in the interim period staff were trying to carry out a programme of group or one to one activities. Care plans recorded activities that people had taken part in. However, we noted that this was mainly resting, walking, watching TV and discussion.

Most people told us that they were satisfied with the activities that were taking place. One person told us, "We have Bingo sometimes and sometimes mobility exercises. Happy with what there is" and another person said, "Sometimes go to the pub – been once since Christmas." However, another person told us that there were no activities on offer. Relatives told us that there was usually an activity available at some time during the day. One relative told us, "She's been on a few trips out – garden centres, theatre, shops etc. There is something on most days."

On the day of the inspection we saw a member of staff playing a game with two people and another member of staff giving someone a manicure, but no other activities.

People told us that their family and friends were able to visit them at any time and were always made welcome. Staff told us that they also supported people to keep in touch with family and friends. One member of staff said, "Some write letters, they can use the phone, or can visit or go out" and another told us, "There are phones in some rooms, or they can use ours." On the day of the inspection we noted that some people had gone out for lunch with relatives and friends.

Good

Is the service responsive?

We saw that the complaints procedure was included in the home's statement of purpose and service user guide, and was also displayed on notice boards around the home. There had only been one complaint received during 2015; this was from a neighbour about the noise staff made when they were smoking outside. We saw that the registered manager had dealt with this appropriately, including sending a letter of apology to the neighbour. The registered manager told us that any compliments or thanks received were displayed on the notice board so that they were available for all staff to see. We observed these on the day of the inspection.

People who lived at the home told us that they were quite confident that they would be listened to if they made a complaint, and could tell us who they would speak to. One person said, "I'd have a word with one of the carers – can't think of any complaints" and another told us, "I'd speak to the manager – if I'm not happy I tell the staff."

Relatives also told us that they would not hesitate to speak to someone if they had concerns. We asked them if they knew how to make a complaint. One relative told us, "The first person would be (name) or (name) but I have never needed to" and another relative said, "I'd see the manager first but I have never needed to."

Staff told us that, if someone raised a concern with them, they would advise them about the complaints procedures at the home. One member of staff said, "I would apologise, ask if they wanted to see the manager or higher and I would write this in the care plan" and another told us, "I would reassure them and notify the team leader and management."

Good

Is the service well-led?

Our findings

We asked people if they thought the service was well-led. A social care professional told us, "The service and level of care has improved since there has been a new manager. The atmosphere always appears to be relaxed but efficient." They told us that record keeping had also improved.

A visiting health care professional told us, "The manager is very good. I would put my mum here – it is 'home from home'." One of the people who lived at the home told us, "Pleasant atmosphere here – I would recommend it" and another said, "I can't fault it – it's homely."

Staff told us that they thought the home was well managed. One staff member said, "Brilliant – nice people – easy to talk to and understanding" and another said, "The manager comes around every day making sure all is ok and she asks for our opinions."

We asked relatives about the culture of the home. One relative told us, "Yes there is – light and friendly. All staff are easy to approach." Another relative told us that they could approach staff at any time and they would listen. Staff told us that they tried to create an atmosphere that was "Open, friendly and homely."

The registered manager told us that they had organised an urgent staff meeting to discuss information that had been in the media about care services. Most staff had attended the meeting. At recent supervision meetings staff had also been given a copy of the whistle blowing policy following a discussion about safeguarding people from abuse, and had signed to record that they had read and understood it. This recorded, "There is zero tolerance towards abuse." This showed that the registered manager had anticipated that staff would have concerns and had arranged a staff meeting and supervision meetings so that these could be openly discussed. The registered manager had also arranged refresher training for staff on safeguarding adults from abuse and whistle blowing.

We saw minutes of other staff meetings that had taken place. The topics discussed included the use of mobile phones, smoking and appearance. Staff were reminded the take more pride when assisting people with personal care.

Staff told us that they attended meetings about every two to three months and that they felt able to express their concerns and ask questions at these meetings. They felt that they were listened to.

There were separate meetings for team leaders. At a recent meeting there had been discussions about team leaders not actually working as a team; we were told that this had improved since the meeting. Staff were also reminded that they must not have their mobile telephone in their pocket and that people who lived at the home must be offered drinks at 08:00, 10:00, 12:00, 15:00 and 17:00 as a minimum.

'Residents' meetings were held at the home and relatives were invited to attend. We looked at the minutes of some recent meetings and saw that people's comments included, "The Queen couldn't get better treatment – it's lovely" and "It's lovely – the lounge and the food are nice." Everyone was asked if they were well and if they were happy in their home.

We saw that surveys had been sent out to relatives in March 2015. The manager told us that ten had been returned so far and that the responses had not yet been collated. One of the questions asked was, "Do you know who to approach should you have any concerns about the standard of care delivered to your relative?" We saw that responses included, "Yes – staff are great. Everyone is helpful, caring and friendly" and "(Names of two staff) although I feel I could approach any member of staff." We saw that there was only two comments that were not positive. One person felt that there was not a lot of interaction between people who lived at the home and staff and another felt that service users did not always look well-presented and clean.

Surveys had been distributed to staff at the beginning of 2015 and these responses had been collated and analysed. A document recording the outcomes had been produced in 'pie chart' format. Responses seen were very positive and there were no areas that required action to be taken. 100% of staff said they could approach the manager with issues, had regular staff meetings, had received induction training during their first week at work and had attended a 13 week review. 95% of staff said that they had attended supervision and appraisal meetings and attended training on food hygiene within the last 12 months. 90% of staff said they had attended training on moving and handling in the last 12 months.

Good

Is the service well-led?

Only one of the people we spoke with could remember receiving satisfaction surveys and two people told us that they were aware of residents meetings; one person had chosen not to attend and the other person told us, "I have been to the odd residents meeting."

We saw the audits that were ready to be sent out to people who used the service and health and social care professionals. There was an additional survey ready to be sent to people who lived at the home specifically about housekeeping and laundry.

The surveys that were distributed and the meetings that took place showed that people who lived at the home, relatives and friends, health and social care professionals and staff were consulted about how the service was being operated.

The registered manager and staff had carried out a number of audits to monitor that systems in place were being adhered to. We saw that care plan audits were being undertaken and that any shortfalls were recorded and re-checked during the next audit. An audit had been carried out in respect of infection control and the registered manager had recorded that they were 88% compliant. There was an action plan in place for the shortfalls identified. Medication audits were carried out on a regular basis. Accidents, incidents and falls were analysed to check whether any patterns were emerging or if any corrective action needed to be taken.

The registered manager was required to complete a key performance indicator (KPI) document and submit it to the head office each month. This recorded a variety of measures such as people who had lost or gained weight, medication errors, infections, incidences of pressure ulcers, details of medication audits, hospital admissions, bed rail usage and care reviews. This meant that more senior managers were also monitoring the safety and well-being of people who lived at the home.

The registered manager told us that there were no financial incentives available for staff but she ensured that staff received praise when they had worked well. She said they had an excellent staff team who supported each other. This was also the view of the staff who we spoke with.

Staff told us about improvements that had been made to the service as a result of them looking into comments or complaints. They said that the menu had been changed in the past after listening to resident's comments and that one relative asked for laundry to be managed in a certain way and this had been done. They also told us that individuals were asked how the home could improve. One member of staff said, "They do a sheet for each resident. We ask residents how we can make it better for them. One person was asked about food; they said they didn't like mashed potato and now they give them roast potatoes."

One member of staff took the lead on infection control and there was a dignity 'champion'. Champions are staff members who take on responsibility for a particular topic. It is their role to share up to date information with the rest of the staff group and to promote their topic within the home. The registered manager told us that the training coordinator was also a moving and handling 'champion' and the dementia lead had undertaken training via Stirling University on how to provide a 'dementia friendly' environment. The registered manager planned that this information would be displayed in the home in the same way the dignity 'champion' information was already displayed.

The registered manager told us that the home was now registered to accommodate up to 37 people but the latest registration certificate shows that they are registered to accommodate up to 44 people. In addition to this, our records show that the manager is registered to manage Molescroft Court but also another of the organisation's care homes where she used to be the registered manager. These anomalies need to be addressed by the registered persons.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Care and treatment was not being provided in a safe way for service users, by assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (1)(2)(h).