Roscarrack House limited

Roscarrack House

Inspection report

Roscarrack House
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Falmouth
Cornwall
TR11 4SB

Tel: 01326312498

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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

Summary of findings

Overall summary

We inspected Roscarrack House on 14 March 2016, the inspection was unannounced.The service was last inspected in May 2013; we had no concerns at that time.

Roscarrack House is a family run residential home that can accommodate up to 19 older people. On the day of our inspection 17 people were living at the service. Roscarrack House is required to have a registered manager and there was one in post. 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.

Care plans contained risk assessments which identified when people were at risk, for example from falls. However, the guidance for staff lacked detail or information on the action staff could take to minimise the risk.

Gaps in Medicine Administration Records (MAR) meant it was not always possible to establish how much medicine people were receiving or whether the amount of medicine in stock tallied with the amounts recorded.

The registered manager had oversight of the service and people, relatives and staff told us they were available and approachable. They were supported by a head of care and an administrative worker. Team leaders had day to day oversight of the team of care workers. In addition the staff team included kitchen staff, cleaning staff, a maintenance worker and a gardener. There were clear lines of accountability and responsibility. There were sufficient numbers of staff to meet people's needs. The registered manager was aware people's needs were increasing and was employing an additional care worker as a result. The new employee would also be able to cover for any staff absence.

People and relatives told us they considered Roscarrack House to be a safe environment and that staff were skilled and competent. People, relatives, staff and professionals spoke of the service in terms of its 'family' feel. Terms such as 'homely' and 'friendly' were frequently used. There was a relaxed and friendly atmosphere in the service. People chatted and joked together and with staff.

Pre-employment checks such as disclosure and barring system (DBS) checks and references were carried out. New employees undertook an induction before starting work to help ensure they had the relevant knowledge and skills to care for people. Training was regularly refreshed so staff had access to the most up to date information. There was a wide range of training available to help ensure staff were able to meet people's needs.

Applications for DoLS authorisations had been made to the local authority appropriately. Training for the MCA and DoLS was included in the induction process and in the list of training requiring updating regularly.

The registered manager and staff demonstrated an understanding of the principles underpinning the legislation. For example, staff ensured people consented before giving personal care. Mental capacity assessments had not been completed as required. The registered manager assured us this would be addressed immediately.

The premises were clean and odour free. People were able to use a shared lounge or stay in their rooms as they chose. Improvements to parts of the building were planned. There was a large decking area immediately outside the dining room where people could eat during warmer weather. Staff told us this was well used.

There were two part-time activity co-ordinators employed and people were supported and encouraged to take part in a range of activities organised in the service. Visitors were made to feel welcome at the service and staff recognised the value of these relationships to people.

We identified a breach of the regulations. You can see what action we have asked the provider to take at the back of this report.

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 was not entirely safe. Risk assessments lacked clear guidance to inform staff on how they could minimise identified risks.

There were gaps in Medicine Administration Records which meant staff might not know how much medicine people had received.

There were sufficient numbers of staff available to help ensure people's safety.

Is the service effective?

Good

The service was effective. Staff had a good knowledge of each person and how to meet their needs.

Staff received on-going training so they had the skills and knowledge to provide effective care to people.

People saw health professionals when they needed to so their health needs were met.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with those wishes.

People were able to make day to day decisions about how and where they spent their time.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

Staff supported people to take part in social activities of their choice.

People and their families told us if they had a complaint they would be happy to speak with the registered manager and were confident they would be listened to.

Is the service well-led?

Good

The service was well led. There was a positive and open culture within the staff team.

Staff said they were supported by the registered manager and worked together as a team.

People and their families told us the management was very approachable and they were asked their opinion about the service.

Roscarrack House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 March 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider 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. We reviewed the PIR, previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at three people's care plans, five people's Medicine Administration Records (MAR), four staff files, staff training records and other records in relation to the running of the home. We spoke with the provider, the registered manager and seven other members of staff. We spoke with five people who lived at Roscarrack House and two relatives. Following the inspection we contacted two relatives and two external professionals to ask them about their experience of the care provided at Roscarrack.

Due to people's health needs we were not able to communicate verbally with everyone to find out their experience of the service. We spent some time observing people and their interactions with staff.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they considered Roscarrack to be a safe environment. A relative said; "It's a safe and secure place. Security was important to us." A regular visitor told us; "It is a safe and friendly place where any resident would be happy and secure."

Care plans included risk assessments which identified what level of risk people were at from various events such as falls and trips, bathing and showering, choking and aggression. Where someone had been identified as being at risk there was a description of the action staff should take to minimise it. This information lacked detail and provided little guidance for staff. For example, one person had become resistant to receiving personal care which could result in them behaving in a way which was difficult for staff to manage. The following information was recorded in the care plan; "Staff to be aware of triggers that can be disruptive to behaviour and try to avoid these situations as far as possible" and "Staff to use diversional techniques." However, there was no description of the likely triggers or diversional techniques. This meant any staff who were not familiar with the person would not have known how to support them well.

We checked a sample of Medicine Administration Records (MAR) and saw there were some gaps in the records. For example, one person had been prescribed two to four pain killers to be taken up to four times a day. It had not been consistently recorded how many tablets the person was having. This meant staff would not be aware how many the person had received over a twenty four hour period. Due to the discrepancies we were unable to check if the amount of medicines in stock was correct. Regular medicine audits were carried out. However, these had failed to identify the gaps in the MAR.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored appropriately. A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records showed the temperature was consistently monitored. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. Apart from the example described above where we were unable to check, the amount of medicine held in stock tallied with the amount recorded.

The staff member responsible for administering medicines wore gloves to prevent any contamination and a tabard indicating they were not to be disturbed to minimise the possibility of errors. When giving people their medicines they explained what the medicine was and ensured it had been swallowed before moving to the next task. All staff with responsibility for administering the medicines had received the appropriate training.

Staff received training in safeguarding adults when they joined the service. This was refreshed at regular interviews to help ensure staff had access to the most up to date information. Staff told us they had no concerns about any working practices or people's safety. They would be confident to report any worries to the manager and believed they would be dealt with appropriately. If staff felt their concerns were not being

taken seriously they knew where to go outside of the organisation to report concerns. Staff told us they would have no hesitation in doing this if they felt it necessary. Comments included; "If I had to do it, I'd do it. Straight away!"

When people required assistance from staff to move around the building or transfer from standing to sitting they were supported safely. Staff carried out the correct handling techniques and used appropriate equipment. Staff were unhurried and focused on the task, offering encouragement to the person while staying alert to any trip hazards or other people moving around.

When any accident or incident occurred it was recorded in people's daily logs. In addition an incident sheet was completed to allow management to carry out audits of these events and identify any patterns or trends.

People were supported by sufficient numbers of suitably qualified staff. As well as care workers the provider employed a maintenance worker, gardener, two activity co-ordinators, four kitchen staff two cleaners and an administration worker. People and visitors told us they thought there were enough staff on duty and staff always responded promptly to people's needs. People had a call bell in their rooms to call staff if they required any assistance. We saw people received care and support in a timely manner. A relative told us; "We visit at different times of the day and there always seem to be enough staff." Arrangements had been made to use an agency for additional staff if required. However, the registered manager told us they had never needed to do this. They commented; "The staff here are brilliant. They all pull together if they need to."

Staff told us people's needs were increasing and some people now needed two members of staff to support them when moving around the building. They said this could sometimes put additional pressure on the staff team and they were concerned the staffing levels would become inadequate. We discussed this with the registered manager who told us they had recognised the increase in demand on staff time and were recruiting a part time member of staff to address this. They told us the new employee would be required to work flexible hours to allow them to cover for any staff absences. When people were receiving end of life care the registered manager arranged staffing levels to ensure staff were able to spend time with the person offering comfort and companionship. They told us; "It's important people aren't alone at that time."

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

The environment was clean and hand gel was available throughout the building. There was a working stair lift in place. Some rooms had en-suite facilities and there was a shower room on each floor. The registered manager told us they were looking into changing one shower room into a bath room so they could offer people more choice.

The kitchen required updating, cupboard doors were textured and difficult to clean and some doors were missing. A glass-washer type steriliser was being used as a dish-washer, this was small and ineffective at drying crockery. This meant tea towels and dishcloths were being used which could increase the risk of cross contamination. A bin had no lid on it. The floor was made of old slate slabs and kitchen staff told us these were difficult to clean and could be slippery when wet. We discussed the problems with the registered manager who told us new kitchen units had been ordered and we saw two cupboards on the premises waiting to be fitted. The refit was expected to be completed in the next eight weeks. Following the inspection visit the registered manager contacted us to tell us they had purchased a new power steam

cleaner to assist with cleaning the kitchen floor. In addition they were investigating the possibility of varnishing the floor with a textured finish to make it easier to clean and less slippery. A cleaning schedule was in place and records showed this was being adhered to. The service had been rated five (good) by the Food Standards Agency.

Good

Is the service effective?

Our findings

People were cared for by staff who were skilled in delivering care. It was clear from our discussions with staff that they knew people well and understood how to meet their needs. Relatives told us they believed staff to be competent.

Newly employed staff were required to complete an induction which included training in areas identified as necessary for the service such as fire, infection control, health and safety and safeguarding. They also spent time familiarising themselves with the service's policies and procedures and working practices. The induction included a period of time working alongside more experienced staff getting to know people's needs and how they wanted to be supported. Before starting working unsupervised the head of care assessed them for competency and confidence.

The registered manager told us all staff would be supported to complete the Care Certificate. This replaced the Common Induction Standards in April 2015 and is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector.

There was a robust system of training in place to help ensure staff skills were regularly refreshed and updated. Responsibility for monitoring training was assigned to the administration worker. Recent training had included First Aid, safeguarding and moving and handling. Staff told us they had enough training to enable them to do their jobs properly. The PIR stated that all staff had either achieved, or were working towards, their Level 2 or Level 3

Staff received regular supervisions and annual appraisals. They told us they felt well supported by management and were able to ask for additional support as needed. Supervisions were either face to face one to one meetings or observations of individuals working practices. Observations were carried out by team leaders who each had oversight of three care workers.

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

People can only be deprived of their liberty 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. Applications for DoLS authorisations had been made to the local authority appropriately. Training for the MCA and DoLS was included in the induction process and in the list of training requiring updating regularly. We saw no evidence that formal mental capacity assessments and best interest discussions had taken place before DoLS applications were made. We discussed this with the registered

manager who acknowledged this stage of the process had been missed. They told us they had carried out mental capacity assessments in the past but not recently. They assured us this would be addressed immediately.

The registered manager and staff demonstrated an understanding of the principles underpinning the MCA. One person's ability to understand the impact of their choices on their health had declined recently. The registered manager told us; "Their capacity varies from time to time. We are aware of it and try offering care at different times. We will have to talk with the GP soon about their capacity though." Staff spoke of the importance of allowing people to maintain choice and control in their everyday lives. Comments included; "If someone is refusing care that's their choice. I'd go back and try again later, but it's up to them."

People and relatives told us the food was of a good standard and the portions were generous. There was always a choice of meals and if anyone wanted something other than what was offered it could be provided. We spoke with the kitchen staff on duty who spoke knowledgably about people's dietary needs and preferences. One commented; "[Person's name] likes tomatoes as long as we take the pips out" and "[Person's name] is gluten free. They have separate chopping board and their own toaster." Care records also contained information about people's dietary needs. The kitchen was open at all times so staff could have access to it if people wanted something to eat when there were no kitchen staff on duty. One person's records stated; "She often enjoys a piece of toast or a sandwich early in the morning."

We observed the lunchtime period and saw it was a relaxed and social occasion. Some staff sat at the dining tables with people and ate their lunch with them. This meant they were able to encourage people to eat unobtrusively and without seeming as if they were continually monitoring them. People and staff chatted together, there were flowers on the table and people had wine with their meal if they wished. There was a large decking area immediately outside the dining room where people could eat during warmer weather. Staff told us this was well used.

People had access to external healthcare professionals such as dentists, chiropodists and GP's. . Care records contained records of any multi-disciplinary notes and any appointments. The registered manager and staff told us they had developed good relationships with local GP's and the district nurse team. A relative told us the GP was always called out if their family member became unwell.

Good

Is the service caring?

Our findings

Not everybody was able to verbally communicate with us about their experience of care and support at Roscarrack House. Those people we did speak with were complimentary about the care they received. People told us; "They're quite kind here, I'm quite happy. Staff have a lot of patience" and "They'll [staff] do anything you want, they're marvellous." Relatives were also happy with the care provided. Comments included; "They've bought my [family member] out of herself and she's got a smile on her face. The difference is amazing" and "For the first time in ages my mum and I can have a laugh." An external professional told us; "Of all the homes I visit I would rate Roscarrack as one of the best."

People were familiar with all staff as well as the registered manager and provider. People, relatives and staff chatted together and there was laughter and joking throughout the day. Some people chose to spend time in a lounge area and it was clear people had developed friendships between themselves and with staff. The provider spent time in the lounge talking with people and we heard people sharing his news after he left. It was a chatty and relaxed atmosphere.

Staff had an understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible. For example, we saw a care worker sitting down with one person to ask them what they would like for lunch that day. They had written the options in large print on a piece of paper and encouraged the person to point to their preferred meal.

People told us they were able to make day to day decisions about how and where they spent their time. The registered manager told us, in the past, people had tended to come downstairs for morning coffee and sit in the lounge socialising until lunch time. This had changed in recent months and people were now choosing to spend time in the lounge after lunch. The registered manager commented; "I don't know how or why it happened really. The pattern just seemed to change." This illustrated how people were able to establish routines which reflected their individual preferences.

People's privacy was respected. Bedrooms were decorated to reflect personal tastes and preferences. People had photographs on display and personal ornaments in their room. Some people had chosen to bring their own furniture into the service. This helped people develop a sense of ownership for their own private spaces. When showing us around the building staff knocked on people's doors and waited for a response before entering. People had lockable, secured storage available in their rooms if they wanted to keep any valuables secure.

People were supported to maintain family relationships. Relatives told us they were able to visit whenever they wanted and were always made to feel welcome by staff. One said; "They always ask if we want lunch. They even suggested we come on a Sunday so we can share a roast." The registered manager told us; "We always try and encourage them [visitors]. This is people's home."

Care plans contained information about people's personal histories. This is important as it helps staff gain an understanding of the person and enables them to engage with people more effectively. The registered

manager and head of care encouraged families to share information with them to help build the histories up.

The registered manager told us they had tried running 'residents' meetings to gather the views of people living at Roscarrack. This had not been successful as people had not wanted to take part. Instead staff had been asked to record in a diary any conversations with people regarding changes they wanted made or suggested improvements. Staff had been told to initiate these conversations frequently to help ensure people's opinions were heard. We looked at the diary and saw one person had asked if they could sometimes have a particular ready meal from a named food store. This had been acted on and the items were now stocked in the freezer so they were quickly available.

Good

Is the service responsive?

Our findings

People who wished to move into Roscarrack House first had their needs assessed to help ensure the service was able to meet their needs and expectations. The head of care would meet with people, and their families if appropriate, to discuss their requirements. The registered manager was aware of the negative impact people's needs could have on each other and worked to help ensure this did not occur. For example, they had recently arranged for one person to move to another service as they recognised they were unable to meet their needs and this was affecting others.

Care plans were an accurate and up to date record of people's needs. The records were well organised and it was easy to locate the information. They were detailed and contained information about a wide range of areas. For example there were sections on mobility, communication, social needs and night time routines. This meant staff had a complete picture of any issues which might have an impact on people's well-being. Care plans gave direction and guidance for staff to follow to meet people's needs and wishes. For example, one person's care plan described how staff should assist the person with their personal care including what they were able to do for themselves. Their care plan stated; "Assist only when required to promote independence and mobility." The care plans were regularly reviewed to help ensure the information remained up to date and relevant.

There were systems in place to help ensure staff were kept informed of any changes in people's needs. Daily records were consistently completed and here was a handover between night staff to staff arriving on shift in the mornings and vice versa. Information from daily records was monitored to identify any patterns that might indicate a change in people's well-being. Any small changes to people's care plans were printed off and put in to the handover book. Staff coming on shift were required to sign to confirm they had read the updated information.

People had access to a range of activities which were chosen to reflect people's interests and preferences. Two part time activity co-ordinators were employed and they were able to plan and organise group activities as well as spend one to one time with people. Activities included exercise sessions and visits from entertainers. In addition staff were pro-active in taking people into the local community, often in their own time. The registered manager told us; "The staff are really good. They will take residents to the pub, the supermarket and church in their own time." The provider regularly visited the service and would also take people out, either to the pub or for walks in the local area. Two members of staff had recently taken out business insurance on their own cars so they were able to take people out for drives. A relative told us; "It's marvellous and there are regular outings."

There was a complaints policy in place which outlined the timescales within which people could expect to have any concerns addressed. There were no complaints ongoing at the time of the inspection. Relatives told us they would approach a member of the management team if they had any worries.

Good

Is the service well-led?

Our findings

There were clear lines of accountability and responsibility within the service. The registered manager was supported by a head of care. Team leaders were responsible for the day to day supervision of care workers. One told us; "It's a bit like a mentor role. But if I'm not here there will be someone else they [carer's] can talk to." Staff spoke about their roles confidently and were aware of who was responsible for the various aspects involved in running the service. The registered manager had oversight of the service and was a visible presence. A relative told us; "You often see her. She helps out, well they all do, everyone digs in."

People, relatives, staff and other professionals all described the service in terms associated with family and friendliness. For example an external professional said; "It's a home from home place." A relative commented; "It's homely, not too clinical." The service was a family run business and this was evident in the atmosphere within the service. A relative said; "The carer's are happy, it seems like a happy environment."

Team leaders had monthly meetings to discuss any concerns regarding people or staff. Full staff meetings were also held but these were infrequent. A carers meeting had been organised in December 2015 which was facilitated by the administrative worker. This was done to help ensure carers felt able to voice opinions without any of the management team being present. Carers had said at this meeting that they felt they were not always given feedback following any incident or concern regarding residents. As a result of this changes to how team leaders reported on any situation were made to help ensure carers were aware of any developments. Staff told us this had been a positive move and they felt communication had improved. The registered manager told us carers meetings could be organised if requested. They were planning to introduce a more regular system of full staff meetings.

Staff said they felt well supported and were able to speak freely about any issues at any time. The registered manager told us they had an open door policy and encouraged staff to air concerns as they arose. Families were asked for their opinion and experience of the service on an annual basis although the registered manager told us they were considering increasing the frequency of this. Results from the last survey were positive.

There were systems in place to monitor the quality of the service provided. Audits were carried out on all recording systems for example, medicines, care plans and accident and incident records. The provider undertook formal monthly visits and produced a report focused on specific areas which highlighted any shortcomings or room for improvement. Policies and procedures for a wide range of areas were in place. The administrative worker was in the process of updating these to make them more relevant and individualised to the service.

Checks were completed on a weekly or monthly basis as appropriate for fire doors and alarms, emergency lighting and Legionella checks. Hoists and slings were regularly serviced to ensure they were fit for purpose.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The provider was not doing all that was reasonably practicable to mitigate identified risks. The management of medicines was not proper and safe. Regulation 12 (2)(b)(g)