Rosebank Nursing Homes Limited

Rosebank Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on the 9 December 2015 and was an unannounced inspection.

Rosebank Care Home is a residential care home providing care and support for up to 28 older people. Rosebank specialises in providing care for people living with dementia.

At the last inspection on the 3 June 2015 the service was rated as 'Good'. After that inspection we received concerns relating to an accident at the home. As a result we undertook a focussed inspection to look into these concerns. This report covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosebank Care Home on our website at www.cqc.org.uk .

There was a registered manager 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.

The service was safe. Where people were identified as being at risk of falls, risk assessments were in place. Risks to people were assessed in relation to the main staircase. Risk assessments were regularly reviewed.

Staff were aware of the risks to people and followed guidance to reduce the risk. Staff were briefed and kept up to date through handover's and meetings and were knowledgeable regarding keeping people safe. Staff had also received training in moving and handling and the management of risks.

Summary of findings

Stair gates had been fitted to the main staircase which were safe and secure. People and staff were briefed on procedures for use of the stairs and we saw they were familiar with these procedures.

Systems to monitor and review people's safety were effective. Systems to notify the relevant authorities regarding safety were also in place.

The registered manager had led by example, maintaining the homes open, honest and caring culture. People and staff were supported through meetings, sharing knowledge, information and learning.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Where people were at risk of falls, risk assessments were in place and regularly reviewed.

Stair gates had been fitted to the main staircase to reduce the risk of people falling.

Good

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

The registered manager had reviewed systems and procedures and introduced measures to keep people safe.

The registered manager had led by example, maintaining the homes culture of an honest, open and caring service.

Good

Rosebank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focussed inspection of this service on 9 December 2015 to check people were safe following an accident in the home on 17 June 2015. An inquest was held into a person's death on 8 December 2015. The verdict was accidental death. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led.

This inspection was conducted by two inspectors. We spoke with three staff, the deputy manager, and the registered manager. We looked at four people's care records and at a range of records relating to the management of the home. The methods we used to gather information included observation and pathway tracking. Pathway tracking captures the experiences of a sample of people and follows a person's care route through the service.

We also looked at reports and information relating to the circumstances surrounding the accident. In addition we attended a meeting of all stakeholders.This was held to ensure people were safe and included the local authority safeguarding team, commissioners and police.

Good

Is the service safe?

Our findings

At our comprehensive inspection in June 2015 the service was rated as 'good'. Following this inspection an accident occurred. This raised concerns relating to falls and the homes main staircase. Following the accident the registered manager took measures to reduce the risks of further incidents.

People were safe from the risk of falls. Prior to living in the home people were assessed in relation to falls and any factors effecting people's mobility and balance. For example, people's mental state, mobility, confidence, hallucinations, susceptibility to infection, eye sight, hearing and medications. Where people were identified as being at risk of falls, risk assessments were in place. For example, one person was independently mobile and used a frame to mobilise. Guidance was provided to staff on how to reduce the risk to this person. This included ensuring the person's frame was within easy reach and maintaining a clutter free environment in their room. We saw this person sat in the lounge with their frame next to them. We also visited this person's room and saw a clutter free environment was maintained. There was a sensor mat on the floor to alert staff at night if the person got out of bed.

Care plans contained detailed guidance on how to support people. One person was independently mobile but was at risk of falls. This person 'sometimes needed assistance from one carer'. For example, when 'getting up from an armchair'. Staff were also advised the person needed 'suitable footwear'. We saw this person wearing flat, supportive footwear and staff we spoke with were aware of the guidance. One member of staff said "We assess everyone for risk of falls and I know how to support anyone at risk of falls".

Staff were aware of the risks of falls and had the knowledge and support to keep people safe. All staff had been trained in moving and handling and received regular briefings and updates on people's support needs. Staff comments included; "When doing risk assessments and care plans for falls, we look at the person's mobility, general health and mental status. This makes our care plans more personalised", "We receive detailed handovers at every shift and we can discuss any concerns at that time", "Our falls care plans are individualised and non- restrictive to resident's freedom. We have enough guidance and support to care for the residents" and "Our handover is very good. We also use it to share any new learning gained".

Following the registered manager's investigation into the accident it was decided to fit stair gates to the main staircase in the home. Bespoke, wrought iron gates were manufactured and fitted at the top and bottom of the stairs. The gates were designed to fit in with the homes 'homely' decor. An electronic lock system secured the gates which could be opened by a member of staff with a key fob. This meant people could only access the stairs accompanied by a member of staff. The gate locks were linked to the homes fire alarm system which unlocked the gates in the event of a fire. This system had been inspected and approved by a fire safety officer.

People's freedom of movement was not restricted by the gates. Access to the upper floors could be gained by the use of a lift or the main staircase. People could ask staff to open the gates to provide them safe access. One member of staff said "I think the gates are a good idea. We have enough staff to accommodate stair usage. It's not an extra job. We have clear guidance on how to support anyone using stairs and the gates". People had been informed about using the gates and thought it was a good idea. One relative said "This is a good step to take because of what has happened. It's an extra layer of safety". During our inspection we saw people freely accessing the staircase accompanied by staff.

Where people were at risk of falls their risk assessments included information relating to the stairs. For example, One person's personal safety assessment noted the person had 'never shown any inclination or indication to go up the main staircase'. This person's room was on the ground floor and a sensor mat was in place to alert staff of movement at night. One member of staff said "I am pleased the gates are on, they are not to stop people being independent".

Good

Is the service well-led?

Our findings

At our comprehensive inspection in June 2015 the service was rated as 'good'. Following this inspection an accident occurred. This raised concerns relating to falls and the homes main staircase. Following the accident the registered manager took measures to reduce risks of further incidents related to falls.

Following the accident the registered manager reviewed systems for assessing people before they lived in the home. This included reviewing falls assessment criteria to cover a wider range of factors that could affect people's risk of falls. The registered manager also consulted with the Care Home Support Service to ensure they followed best practice in relation to falls. For example, the registered manager had introduced a 'falls tracker system'. This monitored all falls in the home and allowed the registered manager to look for patterns and trends in relation to falls and the circumstances surrounding them. One member of staff said "We now have falls tracker in people's care plans and we can record and track the cause of people's falls and identify any trends". All risk assessments had been reviewed and updated, particularly in relation to falls and the main staircase. There was also a system in place to review care plans every month.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events. The registered manager also had systems in place to report safeguarding risks and issues to the appropriate local authority.

People were kept informed through regular meetings. We saw the incident and actions taken by the registered manager were discussed at 'resident' meetings. People were also informed about procedures for the use of the main staircase and the safety gates. Staff were informed through briefings and staff meetings where learning was shared. Health and safety measures were discussed and procedures for the use of the main staircase described to staff. Staff comments included; "After the falls incident we were kept informed of what was happening and supported by management through it all", "We definitely have guidance on using the stairs and maintaining safety" and "As a team we have the resident's interest at heart".

The registered manager had led the service and staff through a distressing time following the accident. They had supported staff and people through the shock and upset of the incident and had led by example, reviewing systems and procedures and introducing safety measures to keep people safe. The registered manager said "This has been a hard time for residents, staff and myself. The tragic accident was awful but the home has pulled together as one to get through it".