Minsa Care Limited

Roselands Residential Care Home

Inspection report

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Date of inspection visit: 28 August 2015
Date of publication: 30/10/2015

Ratings

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

Overall summary

We visited Roselands Residential Care Home on 28 August 2015. The inspection was unannounced. This was the first inspection of the service with this provider.

The service provides residential care and support for up to 17 adults living with dementia or mental health needs. At the time of our inspection 17 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People at the service felt safe. Staff understood how to recognise and report abuse. People's needs were

Summary of findings

supported with relevant risk assessments. There were sufficient numbers of staff to meet people's needs. Safe recruitment procedures were followed when employing staff. Medicines were managed and administered safely.

People were supported by staff with the knowledge and skills to meet their needs. Mental capacity assessments were completed to establish each person's capacity to make decisions about their care and support. Staff were aware of the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported to have a healthy diet and to maintain good health.

People and relatives commented positively about the manager and staff. People and their representatives were supported to express their views and preferences. They were involved in making decisions about care and treatment. Staff respected people's privacy and dignity.

People received personalised care. Care plans were person centred and covered a range of social and healthcare needs. Care plans reflected people's needs, goals and preferences. People were encouraged to take part in activities. The service actively sought and learned to feedback.

Staff spoke positively about the manager who had an open door policy if people, visitors of staff wanted to speak with them. The service had systems of audits, reviews and checks to monitor and assess the quality of service they provided.

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. Staff knew how to recognise and report abuse. There were sufficient staff to meet people's needs and safe recruitment procedures were followed. Medicines were managed safely.

Good

Is the service effective?
The service was effective. Staff had the knowledge and skills they required. People's capacity to make decisions was assessed. Staff were aware of the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported with their health and well-being.

Good

Is the service caring?
The service was caring. People and relatives spoke positively about the manager and staff. They were supported to express their views and preferences. They were involved in making decisions about care and treatment. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive. People received personalised care. Person centred care plans and risk assessments reflected people's needs, goals and preferences. People were encouraged to take part in activities. The service sought, listened and learned from feedback.

Good

Is the service well-led?
The service was well-led. Staff spoke positively about the manager. There were appropriate processes to provide feedback and a system of audits, checks and reviews to assess and monitor the service provided.

Good

Roselands Residential 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 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 28 August 2015 and was unannounced.

The inspection was carried out by one inspector

Before the inspection we reviewed information we held about the service. During the inspection we spoke with three people using the service and five members of staff (including the manager). We periodically observed people during the inspection. We looked at records about people's care and support which included three care files. We reviewed records about people using the service, staff and the carrying on of the regulated activity. We also spoke with two relatives of people using the service and four health and social care professionals.

Good

Is the service safe?

Our findings

People told us that they were happy and felt safe at the service. One person said, "I love it here, I'm really happy." One member of staff said, "[The manager] puts the residents first. He tells us, 'Look after my residents and I will look after you." We found the service had policies and procedures for safeguarding vulnerable adults, whistle blowing and accidents and incidents. Staff answered our questions about safeguarding which showed they understood the different types of abuse and how to report them or escalate concerns. They were fully confident any safeguarding concerns raised would be dealt with appropriately by the manager. The manager had a background in investigating and chairing safeguarding meetings within the health and social care environment.

The service also kept a record of any accidents and incidents involving people and staff. These records provided details of what happened and the actions taken by staff at the time and any subsequent actions. The manager reviewed any incidents and the actions taken. In response, the manager reviewed relevant risk assessments and updated care plans. Any learning from incidents was implemented and passed on to staff in team meetings.

Staff told us that handovers took place between each shift so that staff were prepared for their shift. The handovers enabled the outgoing shift to tell the incoming shift about people's welfare, mood and behaviours and explain any incidents that had occurred.

The service provided a safe and comfortable environment for people, staff and visitors. The building was well maintained. In the six months or so since the provider had taken over the service there had been significant investment and improvements to the building and exterior areas. The manager also told us about planned improvements, such as an external shelter for smokers, landscaping the garden and building a conservatory that would have a positive impact on people's care and support. The service had general risk assessments in place for the building, fittings, equipment and outside spaces. Fire drills took place every other month and staff had received appropriate training in fire safety. Each person at the home had a personal emergency evacuation plan in case of an emergency such as a fire.

We found that people were assessed before they moved into the service. The assessments included an assessment of risks to people and formed the basis for more detailed care planning and risk assessments. These risk assessments were specific to each individual and reflected their needs, goals and preferences. Risk assessments provided staff with clear information about the nature of each identified risk and how to manage it. Staff had a good knowledge of people's needs. The manager reviewed risk assessments every Monday, along with the care plans, or whenever there was a change in people's needs.

There were sufficient numbers of suitable staff to meet people's needs. We looked at staff rotas and staff records. We saw that rotas matched the staff on duty on the day we inspected. Staff told us they were happy with the numbers of staff on each shift. In the morning there were four care assistants including the shift leader. In the afternoon there were three care assistants and at night time two care assistants. The manager was present most days of the week. Staff absences as the result of planned training or leave were covered through the staff rota. Short notice absences as a result of sickness or personal matters were also covered by staff. All staff lived in the local area and at the time of the inspection the manager had not needed to use any agency staff.

We looked at staff records and policies and found there were practical procedures to ensure only suitable staff were employed. We noted there were identification documents and references. Each member of staff had been checked with the Disclosure and Barring Service to ensure they were suitable to work in a social care environment.

Medicines were managed safely. They were securely stored in an appropriate environment. Staff had received appropriate training to administer medicines. We examined records of medicines, received, administered and disposed, including medicines administration records and did not find any discrepancies. None of the people using the service were self-administering medicines, being given medicines covertly or prescribed controlled drugs. Appropriate policies and procedures were stored in the medicines folder to support staff administering medicines. There was an annual medicines review for people using the service with the GP and Clinical Commissioning Group. It had been completed in May 2015.

Good

Is the service effective?

Our findings

People were supported by staff with the knowledge and skills they required to carry out their role. New care assistants completed an induction and were supervised and mentored until they were assessed as competent to carry out the role on their own. One member of staff said, "I had an induction and I'm completing the Care Certificate." We saw in staff records one of the newer members of staff had completed the Care Certificate. The completion of the Care Certificate showed staff had met defined learning outcomes, competences and standards of care expected in the health and social care sectors. Another member of staff told us there had been an increase in training since the new provider took over. Another member of staff said, "We have done so many trainings." We checked staff records which confirmed staff undertook regular training in subjects relevant to their role such as safeguarding, moving and handling, dementia, infection control, pressure ulcer management, first aid and food hygiene.

Staff skills were also monitored and supported by the manager through regular one-to-one supervisions once a month which were recorded in staff files. The manager said, "Supervisions are not structured. They are staff led and I do a lot of listening." The manager told us their observations of staff, clinical matters, training, skills and personal development made up the content of supervisions. The manager wanted it to be a positive process. Staff told us they found the sessions useful.

We saw in care records that those people who were able consented to their care and support. We found the mental capacity of people was assessed to identify their abilities to make decisions about their care and treatment. (The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) provides legislative protection for people who are not able to consent to care and support and ensures people's freedom or liberty is not unlawfully restricted. A DoLS authorisation allows a person to be lawfully deprived of their liberties where it is deemed to be in their best interests).

The registered manager and staff understood the requirements of the MCA and DoLS and when these applied. Staff had recently completed relevant training. We saw evidence of mental capacity assessments, best interests meetings and the involvement of a mental capacity assessor from a local authority for one person using the service. At the time of the inspection the manager had reviewed people using the service and decided there was no need for any DoLS applications.

The service supported people to have sufficient food to eat and liquids to drink. People were provided with a balanced diet and where necessary specific dietary needs were met. We saw assessments in people's care plans that identified their nutritional and hydration needs. Records were kept showing what food and liquids had been consumed. People were weighed regularly to identify any patterns of weight loss or gain. This information fed into a malnutrition universal screening tool with other information to identify the risk or existence of malnutrition. People were provided with meal choices. We saw records of what people ate tallied with menus for that day. Drinks and snacks were made available outside of meal times. One person told us, "The food is good here, I have no complaints." A member of staff told us, "There is better quality food and we ask [people] what they would like."

People were supported with their healthcare needs. They were registered with a local GP's surgery. The manager was in regular contact with the GP to build confidence and trust in the new service. We saw people were supported to meet and attend appointments with healthcare professionals including the hospital appointments, the GP, opticians, dentist and chiropodists. Healthcare professionals visited the service when required. The service also used the modified early warning system to identify when people were at risk of serious illness. This consisted of monitoring specific physiological data and seeking appropriate medical assistance if they exceeded normal parameters. General health and well-being was addressed by the service. For example, the risks of smoking had been discussed with smokers and assistance to stop offered. All of the smokers had capacity to make decisions about the risks of smoking and had chosen to continue.

Good

Is the service caring?

Our findings

We found the service was caring. One relative told us, “My [relative] is so happy. She likes the manager a lot and trusts him.” They also said, “He’s [the manager] done brilliantly. Since he has taken over he has done such a lot in a short time. We are really pleased with the home.” One professional spoke with us about a person using the service. They had seen significant improvements in the person’s health and well-being. They told us relatives were very happy with the service. Another professional commented positively about the service. One professional told us the service was improving under this provider and they were responsive to suggestions. A member of staff said, “All the residents are really, really happy.”

Care was delivered by staff in a patient, friendly and sensitive manner. We observed and listened to interactions between people and staff throughout our inspection. People and staff were seen to be comfortable in each other’s company. Staff treated people as equals. They addressed people as they preferred to be addressed. Most people and staff were on first name terms but one person was addressed more formally. We were told by staff it was that person’s choice. Staff did not rush people to complete tasks, such as eating and drinking, they were encouraged to do things at their own pace. One member of staff told us, “There are no set times for people to get up or leave their rooms.” One person told us, “I get up when I’m ready.”

We found that people, and where appropriate their relatives or representatives, were supported to express their views and were involved in their care and treatment. When we looked at care plans we found evidence of people, relatives and representatives being involved. The service had actively sought to involve relatives by inviting them to reviews of people’s care and support. People’s choices and preferences were clearly recorded. Care plans contained a ‘choices and preferences’ questionnaire for each person. We also saw evidence of people making choices in relation to specific areas of care and support. They had responded to discussions and made comments. For example, one person had stated, “I will tell you if I am unwell.”

Staff respected people’s privacy and dignity. We saw people had a statement of expectations and privacy in their care plans. Care plans regularly referred to care and support being provided with respect for people’s dignity and privacy. A large section of noticeboards in the communal areas were devoted to dignity in care. Both the manager and staff spoke about dignity and privacy when providing care. Staff knocked on people’s bedroom doors before entering. Personal care was delivered in private away from other people. People were clean and appropriately dressed. There was an assessment of people’s independence. Support and encouragement was given in order to maintain or improve independence wherever possible such as with daily living tasks or their own care and support. For example, we saw one person took responsibility for a number of areas of their own care needs. People’s rights and spiritual needs were also addressed in care plans. One person told us they were on the electoral roll and exercised their right to vote.

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the service and continued throughout their stay. The assessment along with other documentation informed the planning of care and support for people. People received personalised care. We looked at care plans and saw they were person centred and addressed a wide range of people's social and healthcare needs whilst reflecting, as far as possible, their choices and preferences. Care plans were based on identified needs, corresponding objectives and the required actions to meet them. The service was responsive to their needs. For example, there were eight people using the service who were living with dementia. In response to their dementia needs staff had completed dementia training which supported them to deliver more effective care. One relative approached staff and told them their relative usually ate a certain type of food. This food was from that point included in the person's diet and cooked specifically for them. In another example, support rails had been installed to provide people with physical support when walking. Although it was a direct response to one person's needs it benefited people in general.

We found there were activities that took place involving individuals and groups of people. Activities were important for people because they enhanced their lives and reduced the likelihood of social isolation. Many activities took place as part of day to day living such as reading, watching TV, conversations, eating meals with other people and colouring books. There were also activities organised by staff and an activities coordinator who worked at the service two days a week. The provider told us they intended to increase the number of hours for an activities coordinator. We spoke with the activities coordinator who told us they were taking some people to a local dementia support group run by Age Uk where there would be activities and the opportunity to socialise with others. Other activities included trips out within the local community and occasional day trips such as one that had taken place the previous month to Brighton. There were activities within the home that included exercise and activities that reflected people's varying capabilities. These included colouring books and 'Let's talk' cards to improve social communication skills. Staff told us they took people out in the local area when there were enough staff available. One member of staff said, "People are taken out to the shops and we have had some day trips."

The service actively sought feedback from people using the service and relatives about their experiences, concerns and complaints. Feedback forms were regularly sent to these groups. Most responses were of a positive nature. The provider published the results and displayed them on the noticeboard in the communal area. The results were summarised into three statements of what the service was doing well, what the service was not doing well and what they were doing to address the negative comments. People using the service also had monthly meetings to discuss the day to day running of the home. We saw minutes of monthly meetings since the service was taken over by the current provider. The manager reviewed any information that was fed back with a view to improving the service.

People were confident that they could raise any matters of concern with staff or the manager. One person said, "He's a very nice boss, he doesn't shout or anything like that." One relative told us, "I would go to the manager or tell the staff." The service had policies and procedures in place for formal complaints but none had been made in the time the provider had been running the service. The manager told us there was always an open door to people using the service and their relatives. One relative told us, "He is very open, I have found he's very open, you can speak to him or phone him anytime."

Good

Is the service well-led?

Our findings

We found that the service was well-led. The manager was appropriately qualified and registered with the Care Quality Commission. We received positive comments about the manager from people using the service, relatives and staff. One member of staff said, "I would approach him about anything, big things or little things." Another said, "[The manager} is lovely, very understanding and very approachable." Another member of staff told us, "[The manager] is a really nice gentleman, very approachable, I'm not afraid to say anything."

The manager told us he welcomed feedback form any source and encouraged staff to bring any ideas or concerns to him. He wanted to create a culture of openness and empower staff. Staff told us there had been an improvement in staff morale and the atmosphere was much calmer since the manager had taken over. Staff meetings took place once a month. Members of staff told us were confident they could speak openly at such meetings and felt valued. In addition to staff contributions these meetings were used to pass on other information. This information included topics such as changes in policies, procedures and legislation or any learning from accidents, incidents and audits.

A wide range of audits, visits, reviews and checks were undertaken by the manager and staff periodically to monitor and assess the quality of service they were providing. For example, the manager checked the daily records for each person whenever he was on duty. There were weekly audits of pillows and mattresses. There was a monthly hand washing audit and reviews of care plans and risk assessments. Every other month there was a clinical audit. Every quarter health and safety, fire and medicines audits took place. The manager also carried out spot checks at weekends and on night duties. All the information was collated and assessed to see if improvements could be made. The manager was also considering external audits perhaps by a manager of another home.

We found that records relating to service delivery and individual people using the service and staff were legible, accurate, up to date and readily accessible. Where required records were stored securely and access was controlled to ensure they were only seen by people entitled to do so. People's care records were accurate, complete and recorded contemporaneously.