Lothlorien Community Limited

Rose Cottage

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 9 February 2018 and was unannounced.

Rose Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rose Cottage accommodates seven people with a learning disability in one adapted building. There were five people using the service at the time of our inspection.

The registered manager had left the service in January 2018 and an acting manager was working at the service. 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.

At the last inspection on 15 August 2016, we asked the provider to take action to make improvements to the way they mitigated risks and make care plans, guidance and records more detailed. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions, effective and responsive to at least Good. The provider had not ensures that actions taken were sustained and the key questions effective and responsive remain rated requires improvement. The ratings for the key questions safe, caring and well-led have deteriorated. This is the second consecutive time the service has been rated Requires Improvement.

The provider did not have adequate oversight of the service. Checks and audits on all areas of the service had not been completed as the provider required and the shortfalls we noted during the inspection had not been identified. Staff had not been held accountable for their responsibilities. Checks on the building and equipment had been completed regularly. Arrangements were not in place for the provider to work in partnership with local authority multidisciplinary team and others, to support and develop the service. Action to reduce the amount of paperwork and repetition in records had not been effective and staff were not able to quickly find information we asked for.

At our last inspection we found that changes in people's health had not been identified and staff had not contacted their health care professionals quickly. At this inspection we found that staff had identified when people were unwell and obtained care and treatment for them. However, one person was eating and drinking less than they usually did. Staff had not followed guidance in the person's care plan to weigh them monthly and did not know that they person had lost a significant amount of weight.

The views of people's relatives, staff and community professionals had been requested but information received had not been reviewed and acted on to continually improve the service. People had not been supported to share their views. One person had made a complaint but this had not been investigated and

resolved to the person's satisfaction. No other complaints had been received.

Most medicines were managed safely. However, the provider's process for the safe checking and storage of medicines that require special storage had not been followed. Guidance for staff about people's 'when required' medicines was not consistently accurate but staff knew when the medicine should be used. People received their medicines in the way they preferred and as their healthcare professional had prescribed.

Staff were not always deployed to the level the provider had assessed as being required to meet people's needs at the service and out in the community. People were supported to attend healthcare appointments but had not been supported to take part social trips out which they enjoyed. People were not supported to take part in a wide range of activities at the service.

People had not been supported to plan their end of life care, in the way they preferred with their representatives and healthcare professionals.

Staff knew what people were able to do for themselves and supported them to complete these tasks as independently as possible. However, plans were not in operation to support people to further develop their independence, for example in relation to household tasks.

Staff were kind and caring to people and treated them with dignity and respect at all times. Staff gave them privacy. People were not discriminated against and generally received care tailored to them. Staff knew people's preferences about the gender of the staff member who supported them. However, the gender of staff working at the service had not been planned to meet people's preferences.

Assessments of people's needs and any risks had been completed. People had planned their care with staff and received support to meet their individual needs and preferences. Processes were in place to analyse any accidents and incidents that occurred and take action to stop them happening again.

People were offered a balanced diet, which met their needs and preferences. Staff helped people who needed support at mealtimes to have as much independence as they wanted.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Assessments of people's capacity to make decisions had been completed. Staff assumed people had capacity and respected the decisions they made. When people needed help to make a particular decision staff helped them. Decisions were made in people's best interests with people who knew them well. The conditions of Deprivation of Liberty Safeguards (DoLS) had been complied with.

Staff knew the signs of abuse and were confident to raise any concerns they had with the acting manager and provider. Staff were recruited safely and Disclosure and Barring Service (DBS) criminal records checks had been completed. Staff had completed the training they needed to fulfil their role.

The service was clean. The building was well maintained and all areas of the building and grounds were accessible to everyone.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. We had been notified of all significant events at the

service.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating under their previous legal entity in the entrance hall of the service and on their website.

At our inspection August 2016 we found the service was in breach of two regulations and required the provider to make improvements. At this inspection we found the provider was in continued breach of two regulations and in breach of three further regulations. This is the second consecutive time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

There were not always enough staff to provide the care and support people wanted.

People were not consistently protected from the risks of unsafe medicines management.

Risks to people had been identified and staff supported people to be as safe as possible.

Staff knew how to keep people safe if they were at risk of abuse or discrimination.

A process was in place to stop accidents and incidents happening again.

The service was clean.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported to remain healthy.

People's needs were assessed with them and their representatives when necessary.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People were supported to make their own decisions.

Staff were supported and had the skills they required to provide the care and treatment people needed.

People were supported to eat a balanced diet.

The building was designed to support people to be as

independent as possible.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported by staff of the gender they preferred.

Staff were kind and caring to people and supported them if they became worried or anxious.

People were given privacy and were treated with dignity and respect.

People were supported to be independent and have control over their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not supported to participate in a variety of activities at the service and in the community.

One complaint had not been identified and resolved to the person's satisfaction.

People were not supported to plan the care they preferred at the end of their life.

People had planned their care with staff. They received their care in the way they preferred.

Is the service well-led?

Inadequate

The service is not well-led.

A registered manager was not leading the staff team. Staff had not been held accountable for their responsibilities.

Effective checks had not been completed on the quality of the service.

Staff had not been supported to provide the service to the standard the provider had set out in their vision of the service.

The views of people, their relatives, staff and others had not been reviewed and used to improve the service.

The provider did not have processes in operation to work in partnership with other agencies to ensure people's needs were met.

Rose Cottage

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 9 February 2018 and was unannounced.

We looked at four people's care and support records, associated risk assessments and medicine records. We looked at management records including three staff recruitment, training and support records and staff meeting minutes. People were not able to tell us about their experiences of the care and support they received, so we observed people spending time with staff. We met everyone who used the service. We spoke with the provider's quality assurance lead, the acting manager, three staff, and one person's relatives.

The inspection team consisted of one inspector. Before the inspection we reviewed the information about the service the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

The provider had considered people's needs and one to one support hours commissioned by the local authority when deciding how many staff to deploy at the service and this was detailed on the staff rota. However, staff had not been deployed to the levels the provider had assessed were required. For example, three staff were required to support people to get up in the morning. When we arrived at the service at approximately 9.30am there were only two staff on duty and a third staff member was due to arrive at 10 am. Everyone was in bed and no one had eaten breakfast. Staff told us people were usually up washed and dress and had eaten breakfast by this time.

Four staff were required to support people to go out in the car. This was because two staff were needed to support people if they had an epileptic seizure in the car. Rotas showed that on 23 out of 27 occasions between 10 January and 9 February 2018 a fourth staff member had not worked at the service. One person's relative told us, "The staff could get our relative to do more, but staffing is an issue". Records we saw confirmed people had not been supported to go out often.

There were staff vacancies at the service and these were covered by agency staff. Regular agency staff who knew people's needs had not been requested by the provider. Staff told us each time a new agency staff member worked at the service they had to learn about people's needs. Staff had reduced the impact on people by making sure that the agency staff member worked alongside an experienced staff member and did not work with one person who did not like being supported by staff they did not know.

The provider had failed to deploy sufficient numbers of staff to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most medicines were stored securely. However, one high risk medicine was not stored in accordance with regulations and the provider's management of medications policy. The medicine was accessible to staff who were not authorised by the provider to have access to it.

The provider's management of medications policy had not been followed when one medicine was received into the service. Staff had not checked the amount of the medicine received but had signed to confirm the amount received was correct. Staff could not be confident that the stock levels recorded were the amount held at the service.

The temperature of rooms where medicines were stored and the medicines fridge had been checked daily and were within the recommended limits. Guidance for staff about people's 'when required' medicines was not consistently accurate but staff knew when it should be used. For example, one person was prescribed cream to keep their skin healthy. Guidance had not been provided to staff about when it was required and where to apply it. Staff explained how they would know that the person needed the cream applied and the areas where it would be needed. The person's skin was healthy at the time of our inspection.

People received their medicines as prescribed by their healthcare professional. Staff training was up to date

and their competency had been checked in the past year. Records of medicines and stock levels were correct. However, medicines checks completed had not identified the shortfalls we found.

We recommend that the service consider current guidance on managing medicines for adults in residential settings and take action to update their practice accordingly.

Risks to people had been identified and guidance had been provided to staff about how to reduce risks. For example, some people were living with epilepsy. Staff had completed training and knew how to respond if someone had a seizure, including administering emergency medicines. Seizure protocols were in place for staff to follow. These included information about the type of seizure the person had, how staff would identify it and when to administer emergency medicines.

The risk of people developing skin damage had been identified and action had been taken to mitigate the risks. Staff supported people to change their position regularly and to use pressure relieving equipment, such as special cushions and mattresses. Staff followed guidance about the correct use of the equipment and it was checked regularly make sure it was working correctly. People did not have skin damage.

A process in place to investigate and learn from accidents and incidents was in place, however accidents and incidents were rare and there had not been a need for it to be used. The aim of the process was to use any accidents or incidents as a learning opportunity and improve the support people received..

Plans were in place and understood by staff about how to support people in an emergency. Each person had a personal emergency evacuation plan (PEEP). The PEEP included important information to help staff evacuate people quickly and what equipment was needed to support people to leave safely. Staff had been trained and told us they were confident to use the evacuation equipment provided.

Staff were trained and knew how to recognise signs of abuse and follow the provider's safeguarding policy. They were confident the acting manager and other senior managers would take action if people were at risk of abuse or being discriminated against. Staff knew about the provider's whistle blowing policy and whistleblowing hotline. They were aware of their ability to take concerns to outside agencies if they felt that situations were not being dealt with properly. The provider had identified possible safeguarding risks to people and had taken immediate action to mitigate these.

The culture of the service was inclusive and everyone was supported to live their life in the way they wanted. Staff knew about people's diverse personal needs and preferences and supported them in the way they preferred. Everyone was treated as individuals.

The provider had recruitment processes in place, these were followed and staff had been recruited safely. The required recruitment checks had been completed. Any gaps in staff's employment history were discussed and recorded. Checks on staff's experience and character had been completed before they began working at the service. These included the checking of references and Disclosure and Barring Service (DBS) criminal record checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

The premises were maintained to ensure people's safety. Regular checks on the environment were carried out. For example, fire equipment was checked to make sure it was working as required. People's bedrooms and communal areas such as bathrooms and toilets were clean and odour free. Consideration had been given to infection control when selecting fittings at the service. Flooring which could be cleaned easily and did not retain odour was fitted in some areas of the building. The kitchen was clean and regular cleaning

schedules were followed. Staff had completed infection control and food hygiene training.

Guidance had not been consistently provided to staff about how to manage the risk of infection from specific viruses. However, staff had completed training and followed safe working practices to minimise the risk of the spread of infection. Staff wore the relevant personal protective equipment, such as aprons and gloves and had easy access to hot water and soap to wash their hands. Risky items such as needles were disposed of in the appropriate secure container.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 15 August 2016 we found that people's healthcare needs had not always been met and people had not always been supported to have access to healthcare when they needed it. Following our last inspection the provider told us, 'The Manager will ensure that all staff are aware of the importance of immediately seeking professional input in the event a person's health deteriorating'. This action had not been taken consistently. At this inspection we found that staff had taken immediate action to seek medical support when people were unwell or 'not themselves', this included calling GPs and emergency services. However, staff had not always taken action to monitor people's health following an illness or a change in their behaviour.

One person had reduced the amount they ate and drank following an illness. Staff recorded how much the person ate and drank each day. However, they had not told the person's GP that they were regularly eating and drinking less than the recommended amount. We looked at the person's weight records and found they had not been weighed since December 2017. Staff had not followed guidance in the person's care plan that they should be weighed each month. We asked staff to weigh the person during our inspection. The person had lost 9.2kgs (approximately 1½ stone) in eight weeks. Staff reported this significant weight loss to the person's GP during our inspection. We notified the local authority safeguarding team of our concerns.

Previously we found that one person's health care records lacked information and staff had not been given clear guidance about how to support the person. Action the provider told us they would take following our last inspection to improve records relating to people's health had not been effective. Staff supported people to attend health care appointments. People were accompanied by staff who stayed with them to offer them reassurance and any assistance they needed to tell their health care professional about their needs. The advice given by healthcare professionals was not consistently recorded in people's records and used to plan their care when they returned to the service. For example, one person had seen a specialist diabetic nurse for a review before our inspection. Staff told us the nurse had revised the usual range for the person blood sugar levels. This information had not been recorded and the person's care plan had not been updated. Some staff we spoke with were not aware of the change and action had not been taken consistently when the person's blood sugars fell below the recommended minimum for them. There was no evidence to demonstrate that this had had an impact on the person's health. However, there was a risk that the person would not receive the support they needed to manage their diabetes.

The provider had failed to do all that was reasonably practicable to mitigate risks to people .This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to have regular health checks such as dental and eye checks. Doctors had reviewed people's medicines. One person's doctor had advised that the time the person's medicine was administered be changed to minimise the risk of side effects and staff followed this guidance. People had hospital passports in place to tell staff and health care professionals about their health care needs.

Staff had received the training they needed to complete their roles and meet people's individual needs. This included epilepsy, diabetes and person centred support. When staff began working at the service they completed an induction, including the Care Certificate and shadowing experienced staff to get to know role and people and their preferences. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. Staff's competency to complete tasks was assessed to check they had the required skills.

Some staff had completed recognised adult social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications staff must prove they are competent to carry out their role to the required standard. Staff received regular training and updates. Refresher training for practical skills such as moving people safely was arranged to keep staff skills up to date. We observed staff supporting people to move safely from one place to another.

The provider had a process in place to offer staff 'regular' one to one supervisions to 'support continuous learning, improve the quality of care, reduce the risk of errors and bad practice and provide support to reduce occupational stress'. This process had not been followed for all staff. For example, one staff member had not received supervision between July 2017 and January 2018. The provider's quality lead for the south east told us this was an area for improvement. Staff had discussed their achievements and set future professional goals at an annual appraisal in accordance with the provider's policy.

We would recommend that the provider fully implement their staff supervision processes.

The provider had a process in place to assess people's needs before they moved into the service. This included meeting with people and their representatives to talk about their needs and wishes. The assessment summarised people's needs and how they liked their support provided. The acting manager was due to meet someone who was considering moving to the service shortly after our inspection. They had not completed this task before and were being supported by a senior manager.

Further assessments of people's needs were completed, such as moving and handling assessments. These were reviewed regularly to identify any changes in their needs. One person had told staff that they would prefer to use a wheelchair when they were out in the community and an assessment was planned to assess their needs and make sure a wheelchair was the best piece of equipment to meet their needs. Information from the assessments was used to plan people's care and support.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff had completed training and assumed people had capacity to make day to day decisions. People were supported and encouraged to make choices about all areas of their lives, including what they had to eat and drink, what they wore and where they spent their time. People's ability to make complex decisions was

assessed when necessary. When people were not able to make a decision, decisions were made in their best interests by people who knew them well, including staff, their representatives and health care professionals. For example, some people used monitors to alert staff if they were having a seizure. When people had not been able to consent to the monitor being used to keep them safe, a decision was made in their best interest.

The provider had a process in place to assess if people were at risk of being deprived of their liberty. DoLS applications had been made and some people had a DoLS authorisation in place. Any conditions on DoLS authorisations had been complied with. People were not restricted and were free to move around the building and grounds as they pleased.

People had been involved in planning the menus at meetings and had been asked about their cultural and religious preferences. Staff knew about person's preferences and individual needs, including allergies and dietary needs. These were recorded in people's records for staff to refer to. Some people required pureed foods to reduce the risk of them choking. These were presented in an appetising way. People were encouraged to eat a healthy diet, including fruit and vegetables. Four out of the five people maintained a steady weight. Staff had completed training in food hygiene.

The building was a small domestic property which had been converted. The doorways and corridors were wide and people moved around easily. Bathrooms had been adapted to meet people's needs. Access to the premises, including the garden was on the same level and people moved around without restriction. A gazebo was erected in the garden in the summer to protect people who enjoyed spending time outside from the sun and heat. People told us they had been involved in decorating their bedrooms. One person showed us the bedding they had chosen, they were very proud of it. Other people's rooms were personalised with pictures and other personal items.

Requires Improvement

Is the service caring?

Our findings

People were able to visit the service before they decided if they wanted to move into Rose Cottage. Staff told us it was "very important" they observed how people got along together to make sure everyone got on well and liked the people they lived with. When people decided they wanted to move into the service a plan was developed with them and their representatives for the move, which included having meals and spending the night at the service so they gradually got used to people and staff, and people and staff got to know them. This process was effective and people were settled living at the service.

Staff knew people's preferences about the gender of the staff member who supported them and this reflected what one person's relatives told us about their loved one. However, all but one of the staff were female and although some people preferred to receive their support from male staff this was not possible. The provider had not considered this when deploying staff to work at the service.

The provider had failed to design service users' care and support to reflect their preferences. This is a new breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's relatives told us they were confident that their relative was receiving the care they needed at the service. Staff treated people with dignity and respect and were kind and caring to them. People were referred to by their preferred names and were relaxed in the company of each other and staff.

Staff knew what people were able to do for themselves and encouraged them to do this, including washing, dressing and some household tasks. One person made hot drinks for themselves and staff and was proud to be responsible for making drinks for staff. Another person took responsibility for tiding up when staff prepared meals. When people required assistance at meals times and they were supported at their own pace, by a staff member who concentrated solely on them.

Staff maintained people's privacy during our inspection, including knocking on people's bedroom doors before entering and closing doors when they supported people with their personal care. Staff described to us how they supported people to have privacy including closing doors if people forgot to do this. Personal, confidential information about people and their needs was kept safe and secure.

People were actively involved in making decisions about their care. A staff member asked one person how they would like their hair styled that day. The person responded "Flat and spiky". The staff member styled the person's hair as they had requested and they person was pleased with it. The person showed other staff their hair and was pleased when they confirmed it was 'flat and spiky'.

People had communication care plans in place which contained information for staff about how people communicated. Staff understood how people told them about the care and support they wanted, including the words and gestures they used. Staff used photographs to help people plan the menu and activities they wanted to take part in. One person liked to know which staff were coming on duty next. Photographs of all the staff were displayed in the hall way and we observed staff use these to answer the person's questions.

Information about when people may need reassurance was included in their care records, such as when they were lonely. We observed staff chatting to the person and holding their hand to offer them reassurance in the way they preferred. Staff chatted to other people and answered their questions when they wanted information and this prevented them from becoming worried or concerned.

People and their representatives had been asked about the person's sexual preferences and cultural and spiritual needs. Where people expressed a preference the provider had processes in place to support people live in the way they preferred and make sure they were not discriminated against.

People were supported by their family, care manager and advocates to share their views about their life with staff and others involved in their care and treatment. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. Staff contacted people's representatives when they needed support. One person's relatives told us staff kept them up to date and involved them in the person's support, such as supporting them to attend appointments.

Requires Improvement

Is the service responsive?

Our findings

People had not been supported to plan their care at the end of their lives. One person's doctor had informed staff at the beginning of January 2018 that the person required end of life care and had told them they would send an end of life care plan. The care plan had not been received and staff had not followed this up with the GP. Staff told us they were making plans for when the person died, including purchasing a funeral package, but had not considered planning the person's end of life care with them and their representatives to reflect their spiritual and individual needs and preferences. Staff continued to provide the person's care in the way the person preferred. We observed the person was calm and comfortable. Action had not been taken to make sure the person would continue to be comfortable and offered reassurance in the way they preferred at the end of their life.

One person's relatives told us their loved one had not been supported to take part in activities they enjoyed such as going out in the evening and going on holiday. Staff told us and records confirmed that people had not been supported to take part in activities in the community as often as they would like. During the week of our inspection, one person had gone out to an appointment and another person had gone with them 'for a ride'. No one had taken part in community activities such as shopping or visiting local cafes.

During our inspection we observed most people stayed in their bedroom and were engaged in activities they enjoyed, such as watching the television or doing jigsaw puzzles. A programme of activities was not in place and people had not been supported to take part in different activities at the service. Records showed that people had taken part in the same activities every day during the week of our inspection.

People had not been offered the opportunity to take part in lifelong learning. Staff told us one person no longer attended a day service they enjoyed. Staff did not know why the person had stopped going to the day service and other ways to support them to meet people had not been explored. Other people were not supported to develop their independent living skills or interests at the service or in their community.

The provider had failed to design service users' care and support to reflect their preferences, including care at the end of their life. This is a new breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints process was available to people, their relatives and visitors in a format which was easy to understand. This was displayed at the service in a communal area. Complaints records showed no complaints had been received. However, one person had complained about their bedroom carpet at a residents meeting in February 2018. Staff told us the person made the complaint often. The person's complaint had not been recognised by staff and the provider's complaints procedure had not been followed to resolve the complaint to the person's satisfaction.

People's relatives told us they were confident to raise any concerns they had with staff and any day to day concerns they had raised had been addressed to their satisfaction.

The provider had failed to operate effective systems to identify, handle and respond to complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 15 August 2016 we found the provider had failed to ensure care plans, guidance and records contained sufficient detail to ensure people received person centred care and treatment appropriate to meet their health needs.

Following our last inspection the provider told us, 'care plans/support plans of all people being supported within the service will be reviewed and updated to ensure information is accurate and reflects their current health needs'. The action taken had been effective and people's care plans contained detailed information about their needs and the support they required. We observed this was followed consistently by staff. People's care plans had been reviewed regularly to make sure they were up to date.

People had been living at the service for several years and staff knew them well. Detailed information about people was available for staff, including agency staff, to refer to, including a one page 'snapshot' of each person. Each snapshot document contained important information about the person, their needs and preferences and how they liked their support provided. People were described positively in their care records, such as 'I have a great smile' and 'I am kind hearted'.

Staff new people's routines and these were recorded in their records for staff to refer to. Staff supported people to follow their routines each day. For example, one person preferred a bath to a shower and liked to have their bath before their breakfast. The person was supported to follow their preferred routine on the day of our inspection.

Inadequate

Is the service well-led?

Our findings

At our inspection on 15 August 2016 we found two breaches of regulation and required the provider to tell us what action they were taking to address these. We received an action plan from the provider stating that all the required action would be completed by November 2016. At this inspection we found that any improvements made had not been sustained and the breaches of regulation continued.

One person's relatives told us a manager was needed to lead the service. Our findings during the inspection confirmed this. A registered manager was not working at the service. The registered manager had left at the beginning of January 2018 and the provider had begun the process to recruit another manager. The service was being managed by an acting manager, with the support of two acting team leaders. The acting manager had not been supported by the provider to fulfil all of their responsibilities, including the deployment of staff. Staff told us and rotas confirmed that the acting manager or a team leader were not deployed on each shift to lead the staff team and they did not always feel supported. Both team leaders were working at the service during our inspection.

The provider described their vision for the service as, 'We aim to provide a safe and homely environment, where all individuals can make their own choices about the support they receive. We do everything we can to improve the health and wellbeing of the individuals we support and as a team we are focused on building positive outcomes for everyone'. Staff had not been supported to provide the service as the provider required and had not been held accountable for their responsibilities. For example, records of the December 2017 staff meeting stated, 'Weighing residents – lets ensure we weigh each month with the level of health issues we have within the home. It's important to ensure that we can monitor wait gain or loss'. Checks had not been completed to make sure staff fulfilled their responsibilities and staff did not know one person had lost a significant amount of weight.

The provider did not have the required oversight of the service and had not identified the shortfalls we found during our inspection. Regular checks on all areas of the service had not been completed in line with the provider's policy. For example, the quality assurance lead told us night time checks should be completed every three months. A check to make sure people received the support they required at night had not been completed at Rose Cottage since August 2017. Other checks completed had not been effective, for example monthly medicines audits had not identified shortfalls in medicines management we found at the service.

The provider had inspected the service in April 2017 and found that improvements were required in a number of areas, including the management of risks and acting on feedback received from people and their relatives. A further inspection took place in September 2017 and found the shortfalls had been 'sufficiently addressed' but action was required to maintain the quality of the service. Further checks of the service had not been completed and the provider was not aware of the shortfalls we found during our inspection.

The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives, staff and community professionals had been asked for their feedback about their experience of the service in the summer of 2017. The information received had not been reviewed to identify any areas for improvement. It was the provider's policy to ask people for their views about the service at monthly 'your voice' meetings. The last meeting was held in February 2018 but meetings had not been held monthly before this. Some people using the service were not able to share their views without the support of staff, their relatives or an advocate. Staff we spoke with during the inspection were not able to tell us if people's relatives and advocates had been invited to attend the meetings to support people to share their views. One person's relative told us feedback they had provided about a lack of holidays for people had not been acted on. Their relative had not been supported to go on holiday for three years, an activity they enjoyed very much.

The provider had failed to act on feedback from relevant people to continually evaluate and improving the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that records in relation to people's care were not user friendly and were difficult to navigate and plans were in place to reduce the amount of paperwork and repetition. This plan had not been effective and staff were not able to quickly find information we asked for about people and their needs. This was a risk as agency staff who did not know people well would not have quick access to the information about people. This continues to be an area for improvement.

Effective systems were not in place to support staff to work collaboratively with other agencies to share information and best practice. For example, staff had not worked with specialist health care professionals to plan the care and treatment people might need at the end of their life.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. We had received notifications when they were required. The acting manager was being supported by a senior manager to learn when notifications needed to be sent.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the entrance to the service and on their website.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to design service users' care and support to reflect their preferences, including care at the end of their life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to mitigate risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to operate effective systems to identify, handle and respond to complaints

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service. The provider had failed to act on feedback from relevant people to continually evaluate and improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to meet people's needs.