Rockley Dene Care Home Ltd

Rockley Dene Nursing Home

Inspection report

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Date of inspection visit:
29 August 2018
06 September 2018

Date of publication:
05 November 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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 took place on 29 August 2018 and continued on 6 September 2018. The first day of our inspection was unannounced. The second day was announced to give the registered provider an opportunity to attend feedback.

We had previously inspected the home in January 2018 and rated it overall as requires improvement. Our key question 'safe' was rated as inadequate and other key questions were all rated as requires improvement. We found breaches of the regulations concerning dignity and respect, need for consent and staffing. We took enforcement action in relation to safe care and treatment and good governance. The registered provider sent us an action plan dated March 2018 which we followed up at this inspection.

Rockley Dene Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rockley Dene Nursing Home provides care and support for people with nursing and residential needs. The home has a maximum occupancy of 34 people. On both days of our inspection, 15 people were living in the home and the local authority had taken the decision to suspend new placements at this home. Due to their concerns, the local authority was visiting on a daily basis to check on the care provided and to ensure shifts were fully staffed.

At the time of our inspection a manager was still registered with the Care Quality Commission. However, the week before our inspection, they left the home and were no longer in day-to-day control. 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 home did not have a deputy manager in post, although by day two of our inspection, a clinical lead had been temporarily appointed to manage the home. The registered provider was in the process of appointing a permanent new home manager.

The majority of nursing staff were agency workers which meant consistency of care was difficult to provide. During our inspection, the registered provider made us aware they would de-register from nursing care and run the home providing residential care only.

We found a continued breach of the regulations as staff training gaps were identified in first aid, fire safety, dementia care and safeguarding. Limited supervision had taken place since our last inspection and there were no staff appraisals.

The storage of medicines was not well managed and staff were not using body maps or topical medication administration records. Individual risks to people had not been properly assessed. Concerns regarding fire safety seen at the last inspection were still evident at this inspection.

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. Deprivation of Liberty Safeguard (DoLS) authorisations had not been appropriately managed. Capacity and consent was not consistently recorded. Staff understanding of DoLS was poor.

Some gaps in the recruitment processes followed for two staff members were identified. Complaints were recorded, although evidence of responses was not always evident.

The home was generally clean and free from odours. Technology was used in the home to assist people in their day-to-day lives.

Dignity and privacy was seen to be improved. People and relatives spoke positively about the staff. People were consistently offered choice during our inspection, although people's preferences regarding waking times had not been respected.

Staffing levels were insufficient to meet people's needs. Calculations used to determine dependency levels had not been updated since May 2018. People were unable to enjoy their afternoon meal in the dining room as there weren't enough staff members to assist people to this area.

The quality of care plans was inconsistent and there were gaps in some of the records we looked at. People and relatives were not consistently involved in the review of their care plan. End of life care discussions had been attempted. One person was receiving support with their religious needs. People received access to healthcare services.

Relatives and staff provided poor feedback regarding the registered manager and the working environment which had developed. Regular meetings for people, relatives and staff were taking place.

The registered manager's audits had stopped in May 2018 and the registered provider acknowledged they had no evidence of their own checks to ensure the service was well managed. Staff told us they were unable to approach the registered provider and the registered manager had discouraged this. The registered provider had failed to meet its own action plan submitted in March 2018.

At this inspection we found people were unlawfully deprived of their liberty and consent and capacity was not consistently recorded. Individual risks to people had not been properly assessed and fire safety was not effectively managed. The storage and records relating to the management of medicines were not safe. There were insufficient numbers of suitably qualified staff deployed to meet people's needs effectively. Staff had not received appropriate induction support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Records relating to people's care needs were not adequately recorded. Detailed records of responses to complaints had not been maintained. There were continued breaches of the regulations and there was insufficient leadership and oversight.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staffing levels to meet people's care needs. The majority of nursing care was provided through agency staff.

The storage of medicines was not well managed. Body maps and topical medication administration records were not being used.

Risks to people concerning pressure mattresses and fire safety had not been appropriately managed.

Is the service effective?

Inadequate

The service was not effective.

People were unlawfully deprived of their liberty as DoLS authorisations had not been appropriately managed. Capacity and consent was not consistently recorded.

Staff had not received adequate support through a programme of induction, supervision and training.

People's required fluid intake had not been calculated. People received access to healthcare.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's waking times were not respected.

Care staff interactions were seen to be positive. Improvements had been made in respect of privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had care plans in place but the standard was inconsistent. End of life discussions had been attempted.

Complaint responses were not evident in the records which meant we could not check these had been appropriately resolved.

A programme of activities was in place. Assistive technology was used in the home.

Is the service well-led?

Inadequate

The service was not well-led.

Relatives and staff gave negative feedback about the registered manager and the working environment.

The registered provider was unable to demonstrate their oversight of the service.

Action taken at the last inspection had not been sufficiently acted on by the registered provider. Audits carried out by the registered manager had not been completed since May 2018.

Rockley Dene Nursing 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 29 August 2018 and 6 September 2018. The first day of our inspection was unannounced. However, as the home did not have a management team in position, we announced the second day of our inspection to give the registered provider an opportunity to be present. The inspection team consisted of two adult social care inspectors on both days of our inspection.

Prior to our inspection, we received information of concern regarding a lack of staff training, unsafe management of medicines, not safeguarding people from abuse and people's bedtime routines not being respected. You can see our findings under the five key questions in this report.

We spoke with a total of three people living in the home and three relatives who were visiting. We also spoke with the clinical lead, registered provider, a consultant to the registered provider, two nurses, eight members of care staff and three visiting professionals. We looked at two care plans in detail and a further 10 care plans for specific pieces of information. We looked at two people's medication administration records.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the registered provider had 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.

Inadequate

Is the service safe?

Our findings

At our last inspection we rated this key question as inadequate. We found there was insufficient information in individual people's risk assessments, infection control was not effective, fire safety was not appropriately managed and there were concerns regarding the safe management of medicines. At this inspection, we found concerns remained in two of these areas and two new breaches of regulation had been identified concerning staffing levels and the safe management of medicines.

We looked at the systems and processes in place to protect people from harm. We asked one person whether they felt safe living at the home and they said, "Yes, I have an alarm and buzzer at my side and bed controls." Another person commented, "Nobody bothers me."

Although people told us they felt safe in the home we found evidence that showed risks to people were not well managed. At the time of our inspection, the registered provider employed a nurse who worked part-time. All other nursing care was provided through agency nurses. On the second day of our inspection the clinical lead made us aware that an agency nurse had fallen asleep on the night shift. They told us regarding the agency nurse, "There was definitely a language barrier there." This meant there was a risk that continuity of care would be difficult to maintain and the registered provider had not ensured, for example, that sufficient language skills had been considered. During our inspection, the registered provider made us aware they would de-register from nursing care and run the home providing residential care only.

Staff training records showed four members of staff had not received up-to-date safeguarding training. At the time of our inspection, the home was without a registered manager and deputy manager. We asked one staff member who had not received safeguarding training how they would report abuse to agencies outside the home and they said, "I wouldn't know where to go." This meant we were not assured that all staff knew how to take appropriate action to keep people safe.
We looked at the records related to safeguarding and could not be sure that appropriate action had been taken. For example, following our inspection, the new home manager made us aware of an allegation of abuse which occurred in July 2018 which was not reported to us. We have reported on this under our key question 'well-led'.

Within people's care records we saw risks relating to their health and safety had been assessed. These included areas such as falls, pressure sores, nutrition and moving and handling. However, we found the risk assessments and associated care plans did not always provide clear information about the actions which should be taken to mitigate risks. For example, when people had special mattresses in place to reduce the risk of pressure sores, the care plans did not include information about the mattress settings.

We checked four people's pressure relieving air mattresses. We found three were not set correctly and in the case of the fourth one, there was no information about what the setting should be and staff were unaware of the correct setting. Therefore, we could not establish whether it was correct or not. If the mattresses are not set correctly they may not be effective. However, we were told by a nurse that no one living in the home at the time of our inspection had any pressure wounds and we were able to confirm this.

We looked at the daily records for one person and saw these showed they had been abusive and acted aggressively towards staff in July 2018. There was no risk assessment in this person's care plan to give guidance to staff about how they could lower the risk of this behaviour or the action they should take if it happened.

Another person had been assessed by a speech and language therapist (SALT) in February 2018 and had been prescribed thickened fluids and a soft diet. The nutritional care plan stated staff should only use the thickening powder if there was a problem with swallowing. The same person had been treated for a chest infection in early July 2018. There was nothing in the records to show staff had considered the possibility this could be related to their swallowing difficulties. The records showed the SALT team had been contacted on 27 August 2018 about this person refusing to follow their dietary advice. The same person was seen to have lost 3kg in weight in early July 2018. They were supposed to have a have a fortified diet and milkshakes for the next four weeks until they regained their usual weight. Weight records showed this had not been achieved and they had since lost more weight. There was nothing in the records to show this had been identified or was being addressed.

We concluded this was a continued breach of regulation 12(1)(2)(b)(e) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as individual risks to people had not been properly assessed and fire safety was not effectively managed.

We looked at fire safety and found this was still a concern. People had personal emergency evacuation plans (PEEPS) which considered a range of needs staff would need to consider in the event of a fire. PEEPS were kept in a fire safety file and a copy of the PEEP was also on the back of the door in people's rooms.

Following our last inspection, the registered provider submitted an action plan in March 2018 which stated they would carry out fire drills every month. They told us these would include all staff and would be carried out at different times. At this inspection, we looked at fire drill records and saw eight members of staff had no experience of a fire drill and none of the drills had taken place on night shifts since March 2018. Staff we spoke with had a mixed understanding of fire safety and their responsibilities. Whilst some staff were able to describe appropriate action, one staff member we spoke with told us in the event of a fire, "To be honest, I wouldn't know where to go."

At our last inspection, we saw a fire evacuation chair was not fit for purpose and we asked the registered provider to take action. At this inspection, we saw the same evacuation chair was still situated at the top of the stairs. One member of staff told us they would use this and named three people they would attempt to move using this equipment in the event of a fire. However, the PEEPs for these people stated staff should use 'fire evac sheet under mattress'. Following our inspection, the evacuation chair was removed.

We saw a fire risk assessment dated January 2018 and noted the fire alarm was tested weekly.

In the follow up to our inspection, we learned the water chlorination and legionella tests had not been carried out in the home since the end of 2016. These checks are important in ensuring a safe supply of water. Other records we looked at showed equipment and buildings maintenance checks had been carried out.

We looked at staffing levels in the home and found there were insufficient numbers to meet people's needs at all times of the day.

One person we asked about staffing levels told us, "Sometimes, they are short, although they did say, "Carers come straight away, they're good with that." Staff we spoke with said there weren't enough staff to

meet people's needs. One staff member said, "There's not enough staff, when I'm in the [name of department], I get asked to assist with (moving and handling) transfers. The buzzers aren't answered quickly enough because most residents need two to do moving and handling." Another staff member said, "It (duties) gets done, but it's delayed. Like if people need the toilet, they could be waiting 20 minutes." Two staff members told us 13 of the 15 people living in the home needed assistance from two staff members to meet their care needs.

We saw the registered manager last completed an analysis of people's needs to support the staffing dependency tool in May 2018, which meant this information was not current in calculating the number of staff required.

On day one of our inspection, the home did not have a registered manager or deputy manager in post. However, neither nursing or care staffing levels had been increased in response to this. On day two of our inspection, a clinical lead had started their employment in the home. Their role was provide day-to-day leadership of the staff team and oversee the quality of care provided.

During the morning there were three care assistants and a nurse on duty. They were supported by a cook, a kitchen assistant, a laundry assistant and a cleaner. The home shared an activities organiser and a maintenance staff member with the home next door, which was owned by the same provider. We observed care staff were busy and had little time to spend with people other than to attend to their physical care needs. Staff from the kitchen and laundry helped at lunchtime to ensure the meal service went smoothly.

After 1pm, care staffing levels reduced, which meant there was one nurse and two care assistants on duty. There was no evening cook and therefore care staff had to prepare, serve and clean up after the evening meal. We saw staff were rushed going from one task to the next. We heard one person crying out in their room, staff went and attended to their personal care needs, but when they left the room the person was still upset. Staff did not have time to sit with person to offer comfort or reassurance. We also observed people were not given the opportunity to go to the dining room at tea time. Instead, everyone had their evening meal in the lounge or their bedroom. A staff member told us this was because staff did not have enough time to support people to the dining room.

On the second day of our inspection, a member of inspection team sat in the lounge throughout the morning and observed as only one staff member briefly entered this area between 10:35 am and 11:55am. We saw three people who were all immobile sat in the lounge. A call bell cord was seen, although this was out of reach as none of the people were independently mobile and able to use this if they needed to request assistance. One of these people had fallen in the lounge twice in May 2018. A staff member told us regarding this person, "If she falls down (in the lounge), it could be 10 minutes before someone puts their head around."

We concluded this was a breach of regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient numbers of suitably qualified staff deployed to meet people's needs effectively.

We discussed our concerns with the registered provider. They told us they were not aware that staffing levels reduced in the afternoon. A consultant told us staffing levels had been changed by the registered manager a week before they left. Following our inspection, the registered provider increased the staffing levels so one nurse and three care assistants worked throughout the day.

We looked at the management of medicines and found this was not consistently safe.

Some medicines are given with instructions which state a maximum temperature they should be stored at. We looked at two people's medicines and found instructions for these medicines stated, 'Do not store above 25 degrees Celsius'. In the first week of September 2018, the medication room temperature exceeded 25 degrees Celsius on five occasions, reaching 29 degrees Celsius on one day. A staff member responsible for the administration of medicines told us they had to keep the door open when they were in the medication room as it was so warm. This meant the room temperature may have cooled by the time they recorded this as it was noticeably cooler outside the room. Following our inspection, we discussed this with the registered provider and they took steps to move the medication to another room which was cooler.

We asked staff whether people's care records included body maps and topical medication administration records (TMARs). One staff member told us, "I'd say some will be in and some might not be." Two other members of staff said no TMARs were available. Both said topical creams were administered by care staff and recorded on daily records and on body maps. We looked at two people's care records and found there was no evidence of TMARs, body maps and their prescribed cream being applied.

We asked the clinical lead about protocols for 'when required' (PRN) medicines. We found these had been reviewed between days one and two of our inspection and the number of PRN protocols had changed from 12 to 26 in this time. This meant PRN protocols had not consistently been available to staff responsible for administering medicines prior to our inspection.

We concluded this was a breach of regulation 12(2)(g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the storage and records relating to the management of medicines were not safe.

We checked a random selection of medicines classified as controlled drugs and found they were correct. The stock balances corresponded with the written records. Medication administration records had been completed correctly indicating people had been given their medicines as prescribed.

A nurse employed by the provider had received up-to-date medication training and had their competency to administer medicines assessed within the last 12 months.

The home was generally clean and for the most part free of unpleasant odours. Staff told us everyone who needed a hoist to move had their own sling. This helped to reduce the risk of cross infection. The service had been awarded a five-star rating for food hygiene by the Food Standards Agency. This is the highest award that can be made and demonstrated food was prepared and stored hygienically.

A newly appointed member of staff told us they had not been allowed to start work until the registered provider had received their references and the results of the criminal records check with the Disclosure and Barring Service (DBS). Background information provided by the DBS assists employers to make safer recruitment decisions. We saw fitness to practice checks had been carried out for the nurse employed.

We looked at the recruitment procedures followed for three members of staff who had commenced employment since our last inspection and found this was not always safe. One staff member had started employment without a reference from their last employer and another member of staff had a DBS, although the provider's record of having seen this wasn't dated, which meant we were unable to confirm this had been received before the staff member commenced their employment. All other recruitment checks had been completed appropriately.

Inadequate

Is the service effective?

Our findings

At our last inspection we rated this key question as requires improvement. We found breaches of the regulations concerning consent to care and treatment as well as a lack of support for staff through a robust training programme. At this inspection, we found continued breaches of the regulations in these areas.

We looked at the support staff received through an induction and ongoing training and found this was poorly managed.

One staff member who was new to the care sector who had started employment in June 2018, told us they had not received any training as part of their induction and had only completed two shadow shifts. Staff who are new to the care sector are expected to complete the 'Care Certificate'. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. This staff member confirmed they had not heard of the Care Certificate. A second member of staff told us they had only received two days shadowing for their induction and no formal training was provided.

We looked at the staff training matrix and found five members of staff had not received first aid training. We also found six members of staff had not received dementia care training and two staff members had not received fire safety training.

We reviewed the supervision and appraisal tracker and found this showed most staff had received one supervision since our last inspection in January 2018. One staff member had not received any supervision in the same period. Both staff and records we looked at confirmed no staff members had received an appraisal in the last 12 months.

We concluded this was breach of regulation 18(2) (Staffing) as staff had not received appropriate induction support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. DoLS requires providers to submit applications to a 'supervisory body' for authority to do so. We looked at records of people's consent, capacity and best interests decisions and saw records conflicted with each other. For example, the 'initial capacity assessment' dated February 2018 for one person stated they did not have capacity to understand awareness of danger and hazards in the home. However, on the same date, they had signed their own bed rails risk assessment.

In one person's care records, we saw a mental capacity assessment had been completed in relation to taking medication. The outcome of the assessment was that the person did not have capacity to make the decision. The form stated in those circumstances a best interest form should be completed. There was no record of a best interest decision for this. We found there were no best interests decisions for four people who had bed rails in place. One person had a mental capacity assessment in place for the use of bed rails,

although the outcome of this assessment was the person did have capacity to make this decision.

Staff we spoke with were consistently unsure about what DoLS were used for and who they applied to. We looked at records relating to DoLS applications and authorisations and found one person's authorisation had expired in April 2018, and an application had not been submitted to renew this. There was no outcome recorded for two DoLS applications which had been submitted in February 2017. A fourth person had no recorded outcome of their DoLS application, although this was later found by a member of the inspection team at a sister home run by the same registered provider. This meant staff at the home this person lived at would not have been aware of any conditions attached to the granted authorisation.

We concluded this was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were being unlawfully deprived of their liberty and consent and capacity was not consistently recorded.

We looked at the adaptation, design and decoration of the home and found there was a lack of dementia friendly signage. We saw the home had pleasant gardens and a conservatory, although the registered manager had set up their office in this area of the home, which meant it was not a space people could fully occupy. Some people had made signs for their doors to suit their preferences.

We asked one person about the quality of food provided for them and they said, "Seems alright enough." Another person told us the food was, "Better this week." We saw fresh fruit available to people in communal areas of the home.

The nurse in charge told us everyone was having their dietary intake monitored. The information was recorded on food and fluid charts. The records did not show what people's target daily fluid intake was. We asked the agency nurse who was in charge of the afternoon shift how they knew what people's target daily fluid intake was and they said they didn't know, staff just recorded what people had. Clinical guidance from the National Institute for Health and Social Care Excellence (NICE) states adults should have a daily intake of 30 to 35mls of fluid per kg of body weight. In the absence of guidance staff would not know whether people were having enough to drink.

We looked at the fluid charts for a person who was identified as being at risk of poor nutrition. Their weight was recorded as 61.5kg on 28 August 2018. Based on NICE guidance this meant they should be having at least 1845mls of fluid daily. The charts showed the person was not receiving this. The charts for 27 and 28 August 2018 showed totals of 595mls and 1030mls respectively. A further three charts dated 11, 12 and 13 August 2018 showed totals of 1250mls, 820mls and 950mls. Another person was weighed as 96.2kg on 6 August 2018. Based on NICE guidance this meant they should be having at least 2880mls of fluid daily. Between 22 and 26 August 2018 their daily fluid intake ranged from 600mls to a maximum of 1800mls.

We concluded this was a breach of regulation 17 (Good governance) as the registered provider had not calculated the daily fluid intake for people and ensured they had enough to drink.

The cook knew about people's dietary needs and preferences. For example, they knew one person was allergic to a particular type of meat. However, this information was not recorded on the dietary needs list displayed in the kitchen. We asked the cook about fortified food, (food with added calories), for people who were nutritionally at risk. They said they only provided fortified drinks which they did by adding fortified milk to hot drinks such as coffee.

Generally, the recording of food eaten during the day was good, showed amounts eaten, snacks mid-

morning and afternoon and when people had refused. However, there were no times recorded so it wasn't possible to see how long the gaps were between meals and the recording at supper time was inconsistent.

We looked at how people were supported to receive timely access to healthcare. One relative told us regarding the care staff, "Chiropody and teeth, I seem to be on at them (to get it sorted)." Care records we looked at contained evidence of the home working with health professionals such as GPs, a dentist and a chiropodist. On a weekly basis, a GP visited and carried out a 'ward round'.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated this key question as requires improvement. We found a breach of the regulations as the registered provider had failed to ensure all staff treated people with dignity and respect and failed to facilitate the most suitable means of communication for people. We saw improvements had been made at this inspection.

One person we spoke with told us, "They (staff) wake me up at six o'clock to give me my tablets and then I can't get back to sleep." We looked at these medicines and saw one was prescribed as 'take one five times a day'. The second medicine was prescribed for 30 to 60 minutes before food. This meant neither medicine had to be given at 6:00am and therefore this person did not need to be disrupted at this time.

During our inspection, two staff members made us aware the registered manager had instructed staff to get people up and ready for 9:30am. One staff member told us, "She told them (staff) it would be abuse not to." Following the departure of the registered manager, this practice was no longer happening.
Our observations were given choice in most of their day to day routines. One person told us, "They come and ask what I want for lunch and ask what I want to drink." We overheard a staff member asking one person, "[Name], what would you like for your breakfast?" The person said they wanted Weetabix and the staff member asked how many they wanted and whether they preferred them served in warm or cold milk.

At this inspection, we found staff were kind and caring in their interactions with people. People and relatives we spoke with were happy with the support they received from staff. One person told us, "They're brilliant (staff). They come and ask what I want for lunch and ask what I want to drink." Relatives comments included, "The carers, I can't praise them enough. The girls (staff) are doing a stunning job", "I am 100 per cent happy with them (care workers)" and "I wouldn't have left [relative] if I didn't think the care was good."

We observed the lunchtime meal service in the dining room. Nine people ate their lunch in the dining room. The meal service was well organised, the atmosphere was calm and people were given time to enjoy their food. People were offered a choice of food and drinks, this was done verbally, we did not see anyone being offered a visual choice. As staff served people's food we heard them telling people what it was.

We saw staff encouraging people to eat and drink and people were offered second helpings. When staff were supporting people to eat this was done with patience and sensitivity. Some people had been provided with plate guards to help them eat independently. We also heard staff encouraging people to be independent. For example, one staff member said to the person they were supporting, "Do you want to try yourself? I'll stay here in case you need help." Most people finished their meals and said they enjoyed the food.

We saw one person assisted to move from the dining room to the lounge was supported by two staff members. They promoted the person's independence by giving them a choice of walking with staff supporting them or travelling in a wheelchair. We observed the staff were patient, supportive and encouraging.

We saw staff asked for permission to clear away one person's used breakfast items. This respected that the person may not have finished their meal. Staff asked the same person if they wanted to move from the dining room, but the person said they were waiting for toast. This was brought to them and staff offered the person a fresh hot drink. We observed as staff explained to another person as they were serving their breakfast, "Here you are [name of person], weetabix, spoon, and cup of tea."

We received mixed feedback from people and relatives regarding their involvement in care planning. However, there was information about people's life histories and their interests in the care plans. This helped staff to get to know people as individuals. Information about people's needs, abilities and preferences had been summarised and put in their rooms so that it was easily accessible to staff. The staff we spoke with knew people well.

Throughout our inspection we observed staff talking with people in a respectful way and noted this had significantly improved since our last inspection. One person we spoke with confirmed staff respected their privacy and dignity. Staff were able to describe how they protected people's privacy and dignity. One staff member told us they ensured they knocked on people's doors before entering their room. They said, "Just like you'd expect someone to knock if you were in your own bedroom."

We saw people's religious needs were considered as part of care planning and one person was attending a religious meeting.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated this key question as requires improvement. At that inspection, we found the provision of activities required improvement and not all documents within the care plans had been completed in full. Staff were seen providing moving and handling assistance which was different to what was recorded in a person's care plan. At this current inspection the registered provider was unable to demonstrate improvements in these areas and the recording of complaints was incomplete.

People had care plans in place but the standard was inconsistent. While there was some information about people's preferences and abilities there was a lack of information about other aspects of their care. For example, two people had no care plans to guide staff on how to manage their needs in relation to epilepsy. One of these people had been identified as having a high risk of poor nutrition, but there was no care plan about this. Information from the internet about diabetes and epilepsy had been printed and put in one person's care records. However, this was not reflected in their care plan and made specific to the person.

We found care was not always delivered in line with people's care plans. For example, one person's care plan stated their feet should be elevated when they were sitting. We saw the person sitting in their room with their feet on a pillow on the floor, not in an elevated position. We observed their feet looked swollen.

We looked at the staff meeting minutes from 10 May 2018 and saw a staff member made reference to one person saying, 'We couldn't get him up this morning because his bum is just red raw so there was no way he could have got up'. We looked at the care records for this person and found there was no reference to this pressure wound.

We found care plans did not have information about the settings for pressure relief mattresses or the type of incontinence products people used.

We looked at the daily records for one person showed over a period of nine days in July 2018, they had been abusive and acted aggressively towards staff. There was no behaviour management care plan to give guidance to staff about how they could try to identify warning signs and manage this behaviour.

We looked at what the registered provider was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We saw people's communication needs were assessed and support plans put in place.
However, we found these did not always give an accurate picture of people's needs. For example, in one person's records, we saw a sensory assessment had been carried out in February 2017 by the local authority sensory team. The assessment identified the person had specific needs and needed written information in a particular format. This was not included in their communication care plan which had been written in April 2017 and reviewed several times since then. The person's care plan stated they had glasses which they wore all the time. Throughout the morning we noticed the person was not wearing their glasses. At lunchtime we

asked a member of staff where the glasses were. They said they had been mislaid, however, within a few minutes they found the glasses. They said the glasses had been in the staff room, but no one knew whose they were.

We concluded this was a breach of regulation 9 Person-centred care as records relating to people's care needs were not adequately recorded.

The activities co-ordinator worked between Rockley Dene Nursing Home and Rockley Dene Residential. On day one of our inspection, they played the piano for people to sing along and they told us they were also playing darts and bingo. People were engaged with the activities provided and enjoyed them. However, staff had little time to stimulate people when the activities coordinator was working at the registered provider's 'sister home'. On the morning of the second day of our inspection, several people were asleep in the lounge for long periods during the morning. One relative felt more activities could be provided. One staff member told us, "I think we could do with our own activities coordinator."

We looked at one person's care records regarding their hobbies and interests. This person chose not to go into communal areas, so we looked for evidence of activities being provided individually for them. There was nothing in their daily records to suggest their preferred one to one activities were taking place. This meant the provision of activities required improvement.

People and relatives knew how to complain if they were dissatisfied. One person said, "I would soon complain if there was something wrong." One relative said, "If I have any concerns, they listen to me." A 'service user guide' provided information on how to complain and said complaints would be acknowledged within 48 hours. However, a timescale for providing a full response was not stated. We saw a visitors and professionals comments book which contained one entry dated March 2017.

We looked at the management of complaints and saw records were inconclusive. Initial records of people's concerns and some evidence of investigations were seen, although it was not clear how the registered manager had responded to complaints as records were not available for us to review. For example, there was no response recorded to complaints received in January, July and August 2018. This meant we were unable to evidence that appropriate action had been taken.

We looked at the complaints file and saw an entry dated 23 January 2018, which the registered manager noted required a supervision session to address concerns with a particular staff member. The supervision records we looked at showed this did not subsequently happen.

We concluded this was a breach of regulation 17(2)(d) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as detailed records of responses to complaints had not been maintained.

The nurse in charge told us none of the people who used the service were receiving end of life care at the time of our inspection. We saw examples of where staff had tried to have discussions with people and their representatives about end of life care wishes. However, we saw some care plans where nothing was recorded about these important aspects of care.

Most people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place. However, the clinical lead had identified concerns about the validity of some of these documents. For example, the address on one person's DNACPR did not show as Rockley Dene Nursing Home. The clinical lead was taking steps to remedy this. There was a system in place to indicate to staff who had a DNACPR.

The home had a call bell system and some people who were at risk of pressure wounds had air flow mattresses in place. One person was seen using a beaker with a spout which meant they were able to independently drink. Staff had obtained an inflatable head rest for one person who found it difficult to support their own head when they had their hair washed. This meant solutions through the use of technology had been applied in the home for some people.

Inadequate

Is the service well-led?

Our findings

At our last inspection we rated this key question as requires improvement. We took enforcement action due to a breach of the regulations concerning good governance, as the registered provider had failed to ensure systems of governance were robust and effective and feedback from people had not been acted on. At this inspection we found there had been failures in management and leadership at the home because improvements had not been made.

At the time of our inspection, we were made aware the registered manager had resigned from their position a week before we visited. The registered provider made us aware they were in the process of appointing a new home manager. The deputy manager had left several weeks earlier, which meant the home was without management support. On day two of our inspection, a clinical lead who was a nurse with managerial experience had started working in the home and had taken day to day responsibility for leading the staff team.

Due to the level of concern at this home, the local authority had recently been visiting on a daily basis to check on the care provided and ensure shifts were fully staffed.

One relative commented regarding the registered provider, "He (registered provider) needs to spend more time here. It's his business." Another relative said, "Things have been more concerning with management. I do think the owners (registered provider) have taken their eyes off the ball." One staff member told us, "I've never met the owner. I think he needs to come and have a meeting with staff."

One month prior to our inspection, the registered provider had employed the services of a consultant to provide oversight of the home. The consultant told us they had found the home had not been adequately led by the registered manager.

We asked the registered provider about their oversight of the home since our last inspection and were told they, "Visited every few weeks" and were in regular contact with the registered manager, although they had no documented evidence to show us how they assured themselves that sufficient improvements had been made in response to the action we took following our last inspection.

One staff member said, "She (registered manager) wouldn't let you speak to (registered provider) or she'd make your life hell." Staff told us the registered provider did not have a visible presence in the home and had visited on a very limited basis. When they had been on site, staff told us the registered manager had taken all the registered provider's time, which meant staff felt unable to approach the registered provider. The registered provider said they had been given suitable assurances about the running of the home by the registered manager.

We spoke with one relative who told us, "[Registered manager] was very good at promising and not delivering. She wasn't exactly truthful. She never had any leadership." Staff told us they were blamed by the registered manager for the areas of concern we identified at our last inspection. One staff member said,

"After the last inspection, it was all our fault." Other staff comments regarding the registered manager included, "She didn't used to acknowledge me", "A lot (of staff) left because of her. If you were a timid person, she'd tend to pick on you" and "I wouldn't get any answer from her."

The registered provider told us they had been contacted by several current and former members of staff following the registered manager's departure. The feedback staff provided demonstrated staff were not working in a supportive environment. Although the registered provider had a whistleblowing policy, we found staff felt unable to discuss their concerns openly with the registered manager or registered provider. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

Following our last inspection, the registered manager sent us an action plan dated March 2018 which stated 'New full audit process for each area to include infection control, training with comprehensive action plans. A report and walkaround document for director (registered provider) to complete at each visit'. At this inspection, the registered provider told us, "There is more work to be done with the warning notices." We found insufficient action had been taken in response to our action and other breaches of the regulations found at the last inspection.

We looked at staff meeting minutes from January, March and May 2018 and saw these were recorded verbatim, meaning it was possible to see what each person in the meeting had said. However, this meant staff could not reasonably be expected to catch up on what was discussed if they had missed the meeting. For example, in March 2018, the meeting minutes were recorded over 35 pages.

The meeting minutes demonstrated a poor working relationship fostered by the registered manager. For example, in May 2018 the registered manager commented regarding the introduction of a new deputy manager, 'Be very aware of [deputy manager] because while you are doing your job properly, you haven't got one issue. If you are not doing it properly she will be on your case'. 'She won't put up with any of your arguments and she won't put up with any of your excuses either'. You often try to shut me out, hence why [deputy manager] is here. She won't be able to shut me out' 'The only thing that bugs me with this home and the only thing at the moment would be that you are wanting me to be your mother'.

Meetings had been held with people living in the home and their relatives. These had occurred in January, March and May 2018. In May 2018, discussions included general satisfaction levels, trips into the community, other activities and decorating in the home.

The registered provider's action plan dated March 2018, stated 'handover to be formulated to include capacity, or identified risk for staff to have full input'. We looked at the handover records and found that up until 23 August 2018, handover notes were written in a lined notebook made up of A4 sheets. There was no template for staff to use and as a result, there was no reference to people's capacity or identified risks. Entries were in some cases, illegible, and the handover notes routinely failed to cover every person living in the home. Staff told us they were instructed by the registered manager to only record where there were concerns regarding people's health and welfare. This meant detailed records regarding people's care needs were not available for everyone living in the home. At the time of our inspection, an improved system of recording handover notes had been introduced.

We looked for evidence of spot checks carried out by the registered manager, but were unable to locate these. One staff member told us, "You never got checked. There was no walking around and making sure everything was alright."

At this inspection, we found the last audits carried out by the registered manager had been completed in

May 2018. This meant there had been no quality assurance checks carried out in the months of June and July 2018. We saw the registered provider had formed an action plan in response to our action following the last inspection. However, it was evident from our findings at this inspection that insufficient action had been taken to comply with the regulations. This meant governance systems were still not robust and effective.

We looked at the file for policies and procedures and saw policies for whistleblowing, fire safety, dealing with intruders, water temperatures, communication and care planning and bed rails were not dated. This meant the information contained in these policies may not have reflected current legislation and guidance.

We asked the agency nurse in charge for two people's fluid charts for the week preceding the inspection. They looked in the archive files, but said they were unable to find them because they had not been filed in any order.

Following our inspection, we were made aware of an allegation of abuse which had not been reported to the Care Quality Commission. It is a legal requirement for the registered provider to notify us of such incidents.

Concerns identified at the last inspection, such as the fire evacuation chair, fire drills and the medication storage room temperature were still found at this inspection. We also identified concerns regarding the management of Deprivation of Liberty Safeguards, staff training and supervision, recruitment, management of complaints as well as the quality and consistency of care records. The issues highlighted under this key question meant there had been a poor response to making the improvements required as highlighted in our last inspection report and the enforcement action. This showed the home had inadequate leadership and oversight.

We concluded this was a breach of regulation 17(1)(2) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were continued breaches of the regulations and there was insufficient leadership and oversight.