Signature of Epsom (Operations) Limited

Rosebery Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

The inspection took place on 24 May 2018 and was unannounced.

Rosebery Manor 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. Rosebery Manor provides facilities and services for up to 95 older people who require personal or nursing care. The service is purpose built and provides accommodation and facilities over three floors. The second floor provides care and support to people who are living with dementia, this area is called The Oaks. The other areas of the home provide care for people requiring 'assisted living'. Some people lead a mainly independent life and use the home's facilities to support their lifestyle. On the day of the inspection there were 86 people living at Rosebery Manor.

At our last inspection on 10 August 2017 four breaches of regulations were identified. The concerns found related to risks to people's safety not being adequately managed, safe medicines practices not being followed, safeguarding concerns not being reported in a timely manner, the lack of effective quality assurance systems and the failure to notify CQC of significant events in line with statutory requirements.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe and Well-led to at least good. At this inspection we found three repeated breaches of regulations relating to the management of the service, how people were kept safe and the failure to submit statutory notifications. In addition, we identified concerns relating to the deployment of staff, responding to complaints, treating people with respect and dignity and providing person centred care.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager had left the service in April 2017. A manager had recently been appointed who supported us to access information during the inspection. The manager informed us they had begun the process of registering with CQC and our records confirmed this was the case.

There was a lack of consistent leadership of the service. There had been five managers in post in the last year. In addition, there had been changes to other key roles. This had led to a negative culture across the service. Quality assurance systems were not always effective in ensuring improvements to the service happened in a timely manner which protected people from risks. Records regarding the care people required were not always up to date and accurately maintained. The complaints log did not contain details of all complaints made and not all complaints had been responded to.

Medicines management systems were not robust which meant people were at risk of not receiving their

medicines in line with prescription guidelines. Risks to people's safety were not always known to staff. The providers policy regarding people receiving night checks was not consistently followed which put people at risk of harm. Sufficient skilled staff were not always deployed and people told us that the high use of agency staff impacted on the care they received. Staff did not always receive the training they required to support them in their roles. Agency staff did not receive supervision to monitor and develop their practice. Permanent staff supervision had improved within recent months. We will continue to monitor this to ensure that systems are embedded into practice.

People did not always receive person centred care and where people's needs changed this was not always responded to in a timely way. People were not always supported by staff who knew them well. Detailed records were not maintained of the care people wanted when nearing the end of their life. Activities provided within The Oaks was not always person centred and did not reflect people's individual interests. People living in The Oaks were not always treated with respect. People did not receive the care they required at mealtimes and staff were task focussed.

In contrast, people in assisted living had access to a wide range of activities and their individual preferences were taken into account. The dining experience for those using the main dining area was positive and people were supported by attentive staff.

Safe recruitment practices were followed to ensure staff employed were suitable for their role. People lived in a clean and comfortable environment and staff practiced good infection control processes. Regular health and safety checks of the premises were conducted and a contingency plan was in place for staff to follow in the event of an emergency.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 (MCA) were followed. Prior to moving to the service, a detailed assessment of people's needs was completed and regularly updated. People told us they enjoyed the food provided and had a range of options to choose from. Healthcare professionals visited the service and appropriate referrals to specialist services were made as required. People were supported to maintain their independence and their religious beliefs were respected.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

During the inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

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?

Inadequate

The service was not safe.

Risks to people's safety were not always managed effectively to ensure people were kept safe from harm.

Safe medicines practices were not consistently followed.

Sufficient skilled staff were not always deployed and there was a high use of agency staff.

Safe recruitment processes were followed.

Safeguarding concerns were reported to the local authority.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive training and supervision to support them in their role.

Healthcare professionals were available to people.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 were followed.

People had access to a range of foods and significant variations in people's weights were addressed.

Is the service caring?

Requires Improvement

The service was not always caring.

People living in The Oaks were not always treated with dignity and respect.

I areas of the service people privacy and dignity were respected.

People were supported to maintain their independence.

People's religious needs were known to the service and support

was provided in this area.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care in line with their care plan and changing needs were not always responded to quickly.

Complaints were not always appropriately responded to and recorded.

People's wishes regarding end of life care were not always recorded.

There was a range of activities provided both within the service and in the local community. However, people living in The Oaks were not always provided with person centred activities.

Is the service well-led?

Inadequate

The service was not well-Led.

There was a lack of consistent leadership within the service which had led to a negative culture developing.

Quality assurance systems were not always effective in ensuring people received a safe and effective service.

Records were not accurately maintained and updated.

The provider had failed to notify the Care Quality Commission of significant events in line with statutory requirements.

Rosebery Manor

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.

The inspection took place on 24 May 2018 and was unannounced. The inspection was carried out by three inspectors, a pharmacy inspector, a nurse specialist and an expert by experience. The nurse advisor specialised in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During our inspection we observed the care people received and spoke with the manager, a representative from the provider, the care service manager and eight members of staff. We spoke with 11 people living at Rosebery Manor, and five relatives

We reviewed a range of documents about people's care and how the home was managed. We looked at eleven care plans, medicines administration records, risk assessments, accident and incident records, complaints records, policies and procedures and internal audits.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2017 we identified concerns regarding the reporting of safeguarding concerns, medicines management and how risks to people were identified and managed. We also made a recommendation regarding the high use of agency staff which people felt impacted on their care. At this inspection we found on-going concerns regarding the support people received to stay safe and with the administration of medicines. There was continued use of high levels of agency staff which meant people did not always receive consistency in their support and on occasions had to wait for their care. There had been improvements in the way in which safeguarding concerns were reported to the local authority.

We received mixed views regarding the support people received to manage their medicines. One person told us their medicines weren't always explained to them, "The nurses dish out the pills and when I asked what something was for I was told that it might help me avoid something that was going around." Another person told us, "My foot creams aren't done every night as I think they should be. Some bother and some don't." One relative said, "I have great concerns about communication about changes in medicines." They relayed an incident where their relative's medicines were not changed as advised by the doctor. Another relative told us, "I feel that I have to stay on top of her medicines as I can't trust the carers here." In contrast other people told us they had confidence in the way their medicines were managed. One person told us, "You can always ask for something for a headache and they will bring you something." A relative told us, "I am very happy that her medicines are locked in her room so there is no room for error."

We found that robust medicines practices were not always followed. Medicine Administration Records (MAR) were in place for each person although these did not always provide clear guidance to staff on how people's medicines should be administered. One person was prescribed a medicine which should be administered once each week. A note in the senior staff communication book stated that the person's medicine had not been administered on the assigned day as it had been signed for earlier in the week. The staff member responsible for writing the note had not investigated this or understood that the person receiving the medicines earlier than planned should have been treated as a potential overdose. We requested this be looked into during our inspection and were informed the staff member signing the MAR earlier in the week had not checked what medicine they were signing against. The person's medicines had not been administered earlier than planned and this was a recording error. A second staff member told us they had tried to administer the medicines earlier in the day but the person's family member had refused it on their behalf. This had not been recorded within the person's records and no further investigation had been completed. We asked the staff member why they had tried to administer the medicine when another staff member had identified a possible error earlier in the week. The staff member told us they had not been informed of this. Records showed that this confusion had occurred as two separate MAR charts were in place for the same medicine. This meant the person had not received their medicines as prescribed and there was also a risk of the person receiving their medicine twice.

MAR records were not always accurately completed. One person did not receive their medicines due to being admitted to hospital. The medicines were still contained within the person's blister pack. However, staff had signed the person's MAR chart to say they had been administered. Two other people's medicines

were being recorded on MAR charts which were dated incorrectly. Medicines administered from the week commencing 21 May 2018 were being documented under week commencing 14 May 2018 on the MAR charts.

Records for PRN medicines (as and when required) and homely remedies (over the counter medicines) were not clearly recorded. One person required their PRN medicines to be administered quickly when experiencing ill health. The person's care plan contained contradictory information as to how long staff should wait prior to administering the medicine. The PRN protocol regarding this referred to a different administration method with doses which did not reflect the medicine prescribed. This meant the person may not receive the medicine they required in the event of an emergency. Another person's records contained PRN guidelines for four different types of laxatives and one anti-diarrheal medicine. It was not clear from the information which medicines were still prescribed for the person. The PRN guidance did not state that advice should be taken from a medical professional prior to administering medicines for diarrhoea to a person who is known to suffer from constipation. This is accepted medical advice in order to ensure the diarrhoea is not overflow diarrhoea which occurs in severe constipation. We requested the service ensured that the above issues were clarified with staff as a matter of urgency. Following the inspection, we were informed this had been addressed.

Staff lacked understanding with regards to the administration of covert medicines (medicines administered without the persons knowledge or consent). One person's medicines were prepared using a medicines crusher. The medicine crusher had not been cleaned between uses which meant there was a risk that the residue from the previous use could contaminate the next person's medicines. When administering medicines covertly involvement from a pharmacist is required to advise on the suitable food or drinks that may or may not be used for each medicine as some foods may decrease the absorption of some medicines. The persons covert medicines record stated their medicines should be given in, 'ice cream, dessert or a cup of tea'. The form stated that this should be checked with the pharmacist but there was no evidence available to say this had been done. We observed the person's medicines were administered in a full bowl of soup, which contradicted what was in the person's care plan-. The person only consumed a small amount of their soup which meant they had not taken the prescribed dose of medicines. Due to the nature of the medicines prescribed this could put the person at risk of significant harm. We checked the persons MAR and found the medicines had been recorded as fully administered. We made the manager aware of this on the day of inspection and they said they would look into it to ensure the person did receive all of their prescribed medicine. We were not able to verify that the actions were taken at the time or to ensure the change was embedded into practice.

Prior to the inspection the provider had informed us that concerns regarding medicines systems had been highlighted following a medicines audit. They told us they believed this was mainly regarding recording rather than administration. A medicines audit had been completed in March 2018 which highlighted errors with twenty people's records of the twenty one people checked. Reassurances were provided that all staff were under-going retraining and would also receive competency assessments. During the inspection the peripatetic care services manager provided evidence that they had met with staff responsible for medicines administration to provide additional training. They added that they had not yet been able to conduct competency assessments due to the time involved in this process. The aim was to complete the reassessments by the end of June 2018. The provider had also introduced spot checks of five people's medicines, three times each day. Incident records showed that 61 medicines errors of varying severity had occurred over the two-month period prior to our inspection. The concerns identified during our inspection demonstrated that the actions implemented by the provider to minimise medicines errors had not been effective. This meant the provider had failed to learn from previous mistakes to ensure that robust medicines practices were followed.

Risks to people's safety were not always effectively monitored and addressed. Records showed that staff had recorded concerns regarding a person having a blister. However, no checks were implemented and no records were available to show that this concern had been addressed and monitored. A month after this observation the person was found to have a pressure sore of significant seriousness in the same area. The provider had acknowledged that with more robust management of the concern, the severity of the damage to the person's skin may have been reduced. Records showed that one person had fallen twelve times over the two month period prior to our inspection. Although the falls record had been updated, the person's care plan was overdue for review by almost five weeks. This meant there was a risk that staff would not have the most up to date guidance on how to keep the person safe. Care plans did not always contain specific guidance regarding the support they required when mobilising. One person's care plan stated, 'needs assistance when mobilising'. The person was assessed as being at high risk of falls and had fallen a number of times. However, staff we spoke with said the person mobilised independently around the service without staff being with them at all times. It was therefore unclear what support staff needed to provide to ensure the person's safety. We spoke with the providers representative about our concerns. They acknowledged that some people's risk assessments needed more detail to guide staff in the action they should take to try to prevent falls. Staff were not always aware of risks associated with people's nutritional needs. One person's records showed that they had been assessed by the Speech and Language Therapy team as requiring a pre-mashed diet due to the risk of choking. During the inspection we observed this advice was not followed and the person was provided with a meal of a normal consistency. We spoke to a member of staff and asked if the person required a pre-mashed diet. They told us, "To be honest with you I don't know. I think it was talked about but now she takes her time and isn't coughing."

Guidance regarding the support people required at night was not clearly recorded and the provider's policy for checking people's well-being at night was not always followed. One person's records previously showed that they had been assessed as being at high risk of falls and were unable to use a call bell to summon assistance. The person's care plan at this time stated they did not wish to be checked throughout the night although later states, 'Please ensure my safety overnight'. There was no guidance to staff as to how staff should do this if no night welfare checks were being completed. The provider policy regarding night time checks states that if a person has requested not to have night time checks then any known risks should be discussed with the person and the conversation fully documented. The policy further stated that a night time risk assessment must also be completed. There was no evidence available to show any risks had been discussed or that a night time risk assessment had been completed. Records showed that during this period the person was found on their bedroom floor more than ten hours after they had last been checked. We found that the person's care plan regarding night checks had been updated and stated they should be checked regularly. However, no guidance was provided to inform staff what 'regular' meant and at what intervals these checks should take place. The provider's policy stated that peoples care plans will detail specifically the number of hours between each check. Record showed that over the two months prior to the inspection there had been 15 occasions when the gap between checks had been over five hours with nine of these occasions the gap being over eight hours. We spoke with the group care quality manager about our concerns. They acknowledged that more detailed guidance was required for staff and that with consideration of the person's needs, the checks needed to be more frequent. Following the inspection, we requested that risk management information for all people requesting not to be checked at night was reviewed. The provider has confirmed that this check has been completed and all records are now up to date. We will check the effectiveness of this during our next inspection.

People did not always receive the support they required to manage their anxiety and behaviours. We spoke to one health care professional who told us that the guidance provided regarding one person's behaviours had not been consistently shared with staff. They told us that although staff were trying, the lack of a consistent of approach was increasing the person's anxiety. They said, "Staff are going in blind and are

getting hurt." Another person's records stated that their behaviour increased as the day progressed. One trigger had been identified as staff telling the person different reasons for her being at Rosebery Manor. Staff had therefore been advised to tell the person a consistent story. However, one staff member told us they did not follow this guidance as they felt that lying to the person was wrong. Records showed the person continued to display behaviours linked with their anxiety. Following the inspection, the provider informed us they had discussed this with the staff member involved. Another person had a risk management plan in place which stated that due to their behaviour towards others a sensor mat should be placed by their door. This would then alert staff when the person was leaving their room so they could offer support and minimise the risk of incidents occurring. During the inspection we observed the person spent the majority of time in their room. There was no sensor mat in place to alert staff of their whereabouts.

There was a failure to ensure risks to people's safety were monitored and reviewed and appropriate measures put in place to minimise risks. There was a failure to ensure that people received their medicines safely which was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ten of the fifteen people and relatives we spoke with told us they felt that staffing levels and the high use of agency staff impacted negatively on the care they received. One person told us, "The level of agency staff has increased significantly since we came and the impact is that they don't know us and we have no relationship with them. Such a pleasure when you see faces that you know." Another person told us, "They are short of staff and there are far too many agency and the two don't blend well together. I have few needs but I often observe people who need help and it's either not seen or recognised. People can expect a better level of care." A third person told us, "There is not many staff, not enough for them to chat to me like you're doing." One relative told us, "I have constant run ins with staff and it's hard to track who's done what when. When they have so many agency people who don't know (family members) changing needs." In contrast some people told us their needs were met safely by the staff supporting them. One person told us, "There's enough for my needs, they're not a lot, I don't bother them." Another person told us, "There are more agency than there used to be but most are kind." One relative told us, "It's never felt short staffed. There are enough and I can't fault them."

Sufficient numbers of skilled staff were not always appropriately deployed to meet people's needs. One staff member told us that staff had noted redness on part of a person's body three days ago. However, care staff and nursing staff had been too busy to coordinate care times so the nurse could see the person during personal care. This meant that although staff had been aware someone needed to be seen by a nurse it had taken three days for them to be examined and assessed for treatment. A staff member supporting people on The Oaks told us they did not feel there were sufficient staff to meet people's needs, "Up here (The Oaks), no, not enough staff. We have nine, but that includes the lead so really it's eight. Lunchtime is a nightmare. We have people in their rooms, people eating in the lounge and at least five people need assisting (to eat)." We observed that the lunchtime service in Oaks was disjointed for people with staff rushing between tasks. This meant that people received support to eat from several different staff members which was disrespectful of their mealtime and did not meet their needs effectively. People were left waiting for lengthy periods for support with their food.

We spoke with agency staff members about their knowledge of people's needs. The agency staff we spoke with were unable to detail the risks to people's well-being and describe to us how these should be managed. One agency staff member told us they were reliant on permanent staff members and the handover sheet to guide them in how to support people. They told us that although they had access to the handheld devices containing people's care plans they did not know all the risks people faced so did not know all the actions they should take to minimise those risks.

Five of the eight staff we spoke with told us they did not always have time to spend with people socially. One staff member told us that although they had the time they needed to give people care, they didn't get the time they would like to sit and talk with people. They gave an example of one person who wasn't feeling 'tip top' today but they did not have the time required to sit and chat with them. Another staff member told us that they did not feel there was enough time to spend with people. They told us, "The expectations of the job here are too much. There is no clarity of roles and this leads to chaotic working and wastes time we could be spending with the residents."

The manager and care services manager told us they had identified that a more stable staff team was required to ensure consistency of care for people. There was an increased emphasis on staff recruitment which had led to seven recent appointments who were in the process of completing recruitment checks. They said that wherever possible consistent agency staff were employed so people saw familiar faces. In addition, the service was changing the way in which staff were allocated. This would mean that staff would consistently be working on the same floor of the service and would therefore gain a greater understanding of people's needs. We will monitor the effectiveness of these developing systems during our next inspection.

Failing to ensure that sufficient numbers of skilled staff were deployed in the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of ensuring care plans were reviewed following falls, improvements had been made to the way in which accidents and incidents were managed. Records showed that there had been an increase in the number of reports received and processed. The manager told us this was due to staff being more aware of their responsibilities to report concerns. Accidents and incidents were recorded on the provider's electronic monitoring systems which meant that they were available for review by senior managers within the organisation at any time. Once recorded on the system a manager was required to update any action taken, who had been informed and any referrals which were required. A review of accidents and incidents was completed during clinical review meetings to monitor any emerging themes or trends.

At our last inspection in August 2017 we found that safeguarding process were not always followed to ensure that people were kept safe from the risk of abuse. At this inspection we found that improvements had been made and relationships with the local authority were developing. However, we found that systems were still becoming embedded into practice and some adjustments to systems were still required. We found one incident which had occurred two days prior to our inspection had not been immediately forwarded to the local authority. The manager told us they were in the process of investigating the incident prior to alerting the safeguarding team. Due to the nature of the incident this should have been discussed with the safeguarding team prior to an investigation taking place. In other instances, we found the local authority safeguarding team had been informed of incidents in a timely manner to enable them to review and where required investigate concerns raised. Following the inspection, the provider forwarded information to clarify the agreement with the local authority regarding the nature of incidents they should be alerted of.

Robust recruitment procedures were in place. Staff recruitment files contained evidence that appropriate information was obtained prior to staff starting work at the service. Checks were made to ensure staff were of good character and suitable for their role. Staff files contained evidence that a face to face interviews had taken place and references were obtained to demonstrate that prospective staff were suitable for employment. In addition, the provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

Safe infection control practices were followed. Staff received training in infection control. We observed that

when supporting people with their care needs gloves and aprons were available for staff use. The laundry area was well organised to ensure that clean items were not contaminated by soiled items. One staff member told us, "We wear PPE (personal protective equipment), wash our hands between everything, and there are different coloured bags for things. Like red bags for soiled items." Cleaning equipment was colour coded to minimise the risk of cross contamination. Cleaning schedules were in place and the building was cleaned to a high standard.

People lived in a safe environment and plans were in place to ensure people would continue to receive their care in the event of an emergency. The building was maintained to a high standard and regular health and safety checks were completed. A maintenance team was employed to ensure that any concerns could be addressed promptly. Fire systems were regularly serviced and fire drills were completed to ensure staff were aware of what action to take should an emergency occur. The provider had developed a contingency plan which gave guidance to staff on the action needed to keep people safe in unforeseen circumstances. A pack containing personal emergency evacuation plans for people along with contact details for responsible individuals was stored securely by the entrance to ensure it was easily available. The administration team checked that the pack was fully up to date each morning.

Requires Improvement

Is the service effective?

Our findings

Relatives of people living in The Oaks who we spoke with did not feel the training provided was sufficient for staff supporting people living with dementia. One relative told us, "Personal hygiene wouldn't be such a problem for (named) if the carers knew how to manage her. There is talk of more drugs but better training may stop her getting so anxious." Another relative told us, "Training isn't good enough for varying high needs. We're disappointed because it's meant to be a specialist unit and between the lack of staff and high use of agency who have even less training, I don't think that they do what they say they do."

People we spoke to from assisted living told us they took for granted that staff received the training they required. However, people expressed concerns regarding the training agency staff completed. One person told us, "I had to train two carers (in a particular element of their personal care). They were grateful that someone had shown them what to do. I was happy to show them but it shouldn't be down to the residents to train the staff." Another person told us, "There should be a standard of training. We should be able to expect that. It's a sign of quality and with more agency that's getting worse."

A matrix of training completed was maintained. This showed that not all staff had completed training in areas including fluid and nutrition, practical moving and handling, practical fire training and medication awareness. In addition, the provider audit had identified that the service had not been offering staff who were new to care the opportunity to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards for those working in the care sector. During the inspection we were informed that senior staff were completing training in order for them to be able to assess staff competence in these areas. However, this meant that until this was identified in May 2018, staff skills in these standards had not been assessed. The providers representative and manager were unable to tell us how long it had been since the Care Certificate had been completed by new staff.

Prior to the inspection the provider informed us that they had recognised that staff supporting people living with dementia required additional training in this area to help them provide proactive support, rather than reacting to incidents as they occurred. They told us the training had been completed with the majority of staff supporting people on The Oaks. However, our observations showed that staff did not always engage with people in a meaningful way and did not provide consistency in the care they provided. The providers representative told us they were aware that staff working in The Oaks required additional support within their roles.

Agency staff did not always receive a comprehensive induction and on-going support. The service had used a number of agency staff on a long-term basis, with some having been in post since the service opened in 2015. Despite this on-going relationship the provider had not ensured that agency staff received supervision to develop their skills in supporting people living at Rosebery Manor and to review their performance. One agency worker told us they had not had any support or supervision at the service or through their agency. They said they maintained their own practice by attending events and courses. They had raised the lack of support with the lead staff some weeks ago and the response was they would consider a full induction when agency start work although this was not yet in place. They told us, "I feel like I am just doing enough to keep

the day going. We end up just running around and if we were left alone without having permanent staff to ask we wouldn't know what to do."

Supervision records in relation to staff employed by the provider showed that improvements had begun to take place. Supervision records from January 2018 to March 2018 showed that from 52 care staff only 14 had received supervision and that no supervisions had been completed with clinical staff or heads of departments. The provider audit had identified this as a concerns and action had been taken to address this. Records for the current quarter were greatly improved, showing the majority of staff had received supervision. We will assess if this process has been embedded into practice during our next inspection.

Failing to ensure that staff received training and consistent supervision to support them in their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people we spoke with told us they enjoyed the food provided and there was always a choice available. One person told us, "The food is good. I have all the choice that I'd ever want." Another person said, "I enjoy my dinners and the cakes." One relative told us, "Downstairs there are always sweet and savoury snacks as well as fruit and I love sitting in the coffee bar with (family member)."

We found a lack of consistency in people's experience of mealtimes. People living on The Oaks were not always supported in a dignified and respectful manner and people's nutritional needs were not always known to staff. We have reported on these concerns within the Safe and Caring areas of this report.

In contrast, people in assisted living were able to choose what time they ate their meal, where they preferred to sit and received support from considerate staff. Most people chose to eat in the restaurant and received an attentive service from the hospitality team. Choices were offered from an extensive menu and a range of drinks were available. Support was provided to people who required it in a discreet and timely manner. Where people required their food to be of a modified consistency such as pureed, choices were available and this was nicely presented. People's specific dietary needs were catered for and within the assisted living area we found this information was shared with hospitality staff. The bistro area in reception had drinks, snacks and cakes available 24 hours a day. People told us they enjoyed this resource and we observed people spent time in this area throughout the day. People's weight was monitored and where significant changes were identified action was taken. A regular food forum was held and people were able to give feedback on the food and offer suggestions.

People received the support they required to access healthcare professionals. People told us that a GP visited the service regularly and they were able to tell staff when they needed to see someone. Where people were unable to communicate their needs in this way, staff monitored their health (except in two cases which re referred to in safe) , requested GP appointments or made referrals to specialist services. People's records confirmed that they had access to dental care, opticians, chiropodists, physiotherapy, dieticians and specialist consultants as required. There was evidence that the service worked with the community mental health team and the intensive support team to support people with their mental health needs where appropriate.

Prior to moving to Rosebery Manor people's needs were assessed to ensure they could be met. Records showed that detailed assessments were completed which covered areas including mobility, health needs, personal care, mental health needs, cognition and life history details. People and their families confirmed that they were involved in the assessment process. Details of people's needs were shared with the relevant teams within the service including care staff, activities, hospitality and housekeeping. When people's needs changed their assessment was reviewed and adapted.

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 people 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 and hospitals are called the Deprivation of Liberty Safeguards.

People's legal rights were respected as systems were in place to ensure that the principles of the MCA were followed. Care records contained capacity assessments in areas including, key padded doors, consent to care, personal relationships and the use of sensor mats. Where people were assessed as lacking capacity to agree to specific decisions, best interest decisions were recorded. This included discussions with relatives who knew the person well and considered people's previous wishes. Where restrictions were in place DoLS applications had been submitted to the relevant local authority. These contained detailed information regarding the person's needs to enable the relevant local authority to prioritise applications.

People lived in an environment which was suited to their needs. Rosebery Manor was purpose built and designed to ensure accessibility to all areas. Lifts to all floors were available from either side of the building which meant people could easily access communal areas. Individual suites were specious and well designed. The Oaks had been designed using research into dementia environments from a leading university. The area was open plan and spacious which enabled people to move around freely. Colours were used to distinguish different areas. People had names and pictures beside their doors to help them identify their rooms.

Requires Improvement

Is the service caring?

Our findings

People told us that although staff were kind they did not have time to get to know them well. People again told us that the high use of agency staff impacted on how caring they felt the service was. One person told us, "They are friendly and caring but they don't get time – they have to get on with other jobs." Another person told us, "They will only have a conversation if they can be bothered so not often." A third person said, "No-one is rude but the agency could be more pleasant." One relative told us, "My (family member) and I didn't feel that such wonderful places existed. It's such a weight off our minds that (family member) is being so cared for."

In contrast, relatives of people living on The Oaks told us they did not feel that staff always treated their family members with respect. One relative told us, "I know them (staff) and they are polite. They have patience with (family member) but they accept a 'no' from her too easily (rather than encourage). That can mean that she goes to bed in her day clothes or doesn't get a shower. There's a lot that I'm not happy with. I have seen them just ignoring people when they are calling out. They should sooth them but only a few are good at that." Another relative told us, "I don't think that they always treat (family member) with dignity. I found her asleep in the dining room with porridge on her and on the table where she had struggled to eat it. Napkins aren't always available, that wouldn't happen in any of the other dining areas here. I think that it's partly the training and partly the nature of some of the people caring for those with high needs."

People living in the Oaks did not receive the support they required to eat in a dignified manner. We observed that people were waiting for long periods to be served and during this time there was little interaction from staff. One person sat at the dining table for 35 minutes waiting for their starter whilst other people had received their starter and main course during this time. This led to some people falling asleep and others appearing anxious or confused. Staff sat with people who required support to eat for short periods of time before moving to help someone else. On one occasion we observed a staff member support someone with their food for a few minutes. They then stood up and examined the person's head before leaving the area without speaking to the person or offering any reassurance. By the time the person received support from another staff member their food would have been cold. One staff member had positioned themselves at the dining table with their back directly turned away from a person sat at the same table. The person received little encouragement to eat and left the majority of their meal. There was little interaction with people throughout the lunchtime service and staff were constantly moving around. This created a rushed and task orientated atmosphere which was not respectful to the people who required support.

Staff did not always interact with people living in The Oaks in a respectful manner. We observed one person had fallen asleep in the communal lounge whilst sitting in their wheelchair. Staff moved the person without speaking to them to access the storage baskets next to them. On the second occasion the staff member moved them, the person roused and the staff member briefly spoke to them. We observed another person trying to gain the attention of a staff member. The staff member replied that they were just going to the toilet and would come straight back. However, they did not return to speak to the person. The person later summoned their attention again and the staff member agreed they would find something out for them and let them know. Shortly following this the staff member returned to tell their colleagues they were going for a

break without further acknowledging the person's request. Another person had come into the communal lounge for a cup of tea and remained there for 55 minutes. During this time no staff engaged with the person and they returned to their room. A fourth person went into the dining area and asked where they could sit. The staff member told them, "You can sit there, but you may have to move when it's lunchtime." The staff member then said to their colleague, "I am trying to set the tables for lunch. (They) really should be in the lounge as (they've had their) breakfast." This showed a lack of respect for the person and their home.

Failing to support and engage with people in a respectful and dignified manner was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast, observations of interactions within assisted living were positive. People and staff appeared to get on well and conversations were relaxed and friendly. We observed staff paying people compliments regarding their appearance, asking how they were and if there was anything they needed. Staff were observed to offer people choices and options regarding where and how they spent their time. One person was enjoying singing and dancing to music and when staff passed they briefly joined in. The person clearly enjoyed this and laughed with the staff involved.

People's privacy was respected and their independence was promoted where possible. Care plans highlighted areas where people should be encouraged to maintain their independence such as with their mobility and their personal care. We saw people were able to move freely around the building and some people continued to access the community independently. We observed staff supported people with their personal care discreetly with doors closed. Staff knocked on people's doors and waited for a response before entering. Staff were able to tell us how they ensured people's privacy. One staff member told us, "All staff knock on people's doors before we go in. If someone had visitors I wouldn't interrupt them unless they'd called. We keep doors closed and curtains for care and try and cover people up. I'd always ask what someone could do for themselves."

People's religious beliefs were respected. Assessments and care plans contained information regarding people religious beliefs. People were supported to attend church services and transport was available to take people to three different churches on a Sunday morning. In addition, a monthly service was held at Rosebery Manor. One person told us, "The regular church service here is very important to me. I always get along to that."

There were no restrictions on visiting times and people and relatives told us they were made to feel welcome. We observed people were able to receive their visitors in the privacy of their own room or in one of a number of communal areas. Drinks and cakes were available to visitors and people were able to invite their family or friends to join them for a meal. Prior to the inspection one relative had contacted us regarding concerns around visiting their family member. This is currently being discussed with other professionals supporting the family.

Requires Improvement

Is the service responsive?

Our findings

People in assisted living said they were consulted about their care and were involved in developing their care plan. One person told us, "I have my care plan and can say what I need when." Another person told us, "I feel that we're generally listened to and can decide on our own routines." A third person said, "I choose to have an early night – around 7:15pm and if I wanted to change that I would just say."

Despite these comments we found that people's changing needs were not always responded to. We asked the manager if anyone was cared for in bed. They told us following a significant injury one person had returned from hospital the previous day and would therefore receive their care in bed. However, we observed they were up and sat in their wheelchair when we visited them. The person was almost laid in their wheelchair and staff spent several minutes trying to get their feet to stay on the foot plates of the wheelchair as the person's position made this difficult. The person looked uncomfortable and spent the majority of their day with their eyes closed. The person's care plan had not been updated to reflect the care they needed following their injury. Staff had not considered the person's comfort or what positioning would reduce the risk of causing them pain. We spoke to the manager who told us that considering the person's injury they had expected them to receive their care in bed.

Care plans were not consistently followed to ensure people received the care they required and wanted. One person's care plan stated they preferred to have a shower and their hair washed every day. Care records showed that this was not always done and did not record the person had refused. Care plans recorded the gender of staff people preferred to support them. However, records showed that these preferences were not always followed.

Staff did not know people well in order to provide person centred care. During the inspection we spoke with five care staff regarding the needs of people we saw them supporting. Although staff were able to provide some basic information regarding regular visitor's people received, they were unable to tell us about people's current needs and preferences, life histories or past occupations in any detail. The information we received from staff related to tasks which needed to be completed rather than person centred information.

Care plans regarding the support people wanted when nearing the end of their life were not always detailed. Some people care records showed where they would like to receive their care and who they would like to be contacted. However, there was little detail regarding people's preferences to ensure their care at this time was personalised. The manager told us that some people preferred not to discuss this but agreed this should also be recorded. The providers representative told us this was an area of development and they had recently revised the policy regarding end of life care. We will monitor the development of the care people receive in this area during our next inspection.

People living in The Oaks did not have always have access to meaningful activities. Relatives and staff told us this was an area which required improvement. One relative told us, "The only thing is that the activities sometimes don't happen." Another relative said, "I've told them activities aren't as good here as downstairs (assisted living)." Relatives did say that some activities were enjoyed by their family members such as

singing groups and exercises. One staff member told us, "I feel they need their own garden. We can't take them as there are not enough staff to take them downstairs and leave enough up here."

Although a separate activity programme was available for people living in The Oaks we observed that people received little interaction or stimulation throughout our inspection. During the morning a relative asked a staff member if they would be taking people for a walk around the garden as it said on the activities programme. The staff member looked at their electronic recording device and replied, "It doesn't say anything like that on my phone." We observed that no one went out during the morning. At 11:30 am staff brought out musical percussion instruments and put on some music. Staff spent five minutes supporting people to use the instruments in time with the music. Following this the music was left on for a further 45 minutes although there was little interaction with people. In the afternoon two people came to join in the activity downstairs whilst others remained in The Oaks. We viewed activities records for one person for the previous three weeks. This showed the person had received visitors on two occasions, been for a walk twice, watched TV once and recorded 'other' on one occasion.

The failure to ensure people received person centred care and activities in line with their needs and preferences is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Activities provided in assisted living were varied and person centred. People told us they enjoyed the activities provided and the was a good range things to try. One person told us, "They do well with activities and they have an activity forum so you have a chance to say what you'd like." Another person told us, "There's plenty going on if you're inclined to but they accept that I'm self-sufficient and not a 'joiner'."

Activity programmes were delivered to people's suites and there was a copy prominently displayed in reception. There was a dedicated activities team in place who worked across a seven-day week. Activities available included arts and crafts, quizzes, flower arranging, bridge, bowls, exercise and excursions to various places of interest. A range of entertainers and speakers were also booked to visit on a regular basis. People's personal interests were catered for ensure they were able to maintain their hobbies. One person told us, "Three of us are interested in football so they arrange a bus to go to Sutton United and a couple of the off-duty carers and the chef, come as well. We have a meal and watch the game. Great." Another person said, "I used to be a designer and I enjoy the art classes and I'm learning to play bridge." During the inspection we observed people taking part in a singing group. People clearly enjoyed the music being played and spent time dancing and singing with staff.

Complaints were not responded to in line with the providers policy. A complaints log was maintained which we were informed was an up to date record of all complaints received by the service. However, we were aware of two complaints from a relative which had not been recorded on the log. The manager confirmed they were aware that the relative's complaints had not been responded to and were unsure why these had not been recorded. Records showed a complaint relating to one person's care had not been responded to. The manager told us they were unable to find a response to the complaint and did not believe this had been completed by the previous management team. One relative told us had raised a number of concerns regarding their family members care. They told us, 'I make frequent complaints, generally via the leader on this floor. It's the only way to get straight answers but it often has to go through to a higher level and that takes too long." The complaints log seen did not reflect that concerns had been received and reviewed in relation to this person's care. The lack of accurate complaints monitoring meant that the service was unable to identify and themes and ensure that concerns were not repeated.

The failure to address and monitor complaints was a breach of regulation 16 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2018 we found that quality assurance systems were not effective in identifying concerns and make improvements and that records were not always accurately maintained. The provider had failed to ensure that CQC were informed of significant events which had taken place. At this inspection we found on-going concerns regarding governance and the way in which the quality of the service was monitored. The provider had not ensured that effective systems had been implemented to ensure CQC were notified of significant events in line with statutory requirements.

We spoke with six people and two relatives regarding the management of the service. All told us they had concerns regarding the high turnover of managers and how this had impacted on the service they received. Comments included, "Managers, it's a joke. They change so often. Either they give the wrong person the job or don't help them but they don't stay.", "They have such obvious difficulties with management. It all comes down to the strata's of administration that are too separate. It's a system that doesn't work here and all the issues demonstrate that.", "The place is rudderless. The proof is in the high turnover which is sad for us.", "It's wrong that no explanation is given. Managers just vanish, goodness knows why.", "The leaders on the floors don't get the right support and it all just wobbles. We don't get quick responses and issues drag on." And, "We have had four or five managers which has had a major, detrimental impact on the overall leadership."

There was no registered manager in post. The last registered manager had left the service in April 2017 and since this time there had been five managers in post. In addition, there had also been a number of changes within other key management roles. This had led to instability within the service and a lack of consistency for people, relatives and staff. Staff told us that the instability in the management team had led to a negative culture within the service and to staff feeling demoralised. One staff member told us, "We don't get thanked enough. There have been so many changes, Mangers don't even introduce themselves, don't even say hello. If I didn't have my badge on they wouldn't know my name." Another staff member told us, "There have been many changes in the management but the care is still messy. Lots of promises were made but there was no action." Another staff member told us, "You have to be strong to work here". One staff said that although they received support from regional and lead staff, they felt there was something wrong within the overall culture. They told us they felt they needed a manager who would stay and bring stability.

We spoke with the manager who was covering the service, the clinical services manager and the providers representative regarding the management oversight and culture of the service. The manager told us that they felt staff had welcomed them during the time they had been in post and staff appeared more relaxed. They told us they were in the process of working through the service action plan and recruitment of a stable staff team was currently their main priority. They said that although there had been changes in the senior management team the lead staff in each department had provided some stability in the service which they hoped to build on.

The provider had not ensured that systems implemented to address concerns were effective and transparent. Concerns regarding medicines management systems have been identified during the past four

inspections undertaken by CQC. Whilst improvements were noted during our inspection in November 2016, these were not sustained. Following our inspection in August 2017 the provider submitted an action plan stating they would become compliant with all regulations by the end of November 2017. Actions included ensuring staff medicines competencies were reviewed and that all errors were recorded and tracked to identify trends. During a meeting with the provider in April 2018 we were informed that issues had been identified with regards to medicines administration and that action to address these concerns had been taken. The provider reassured us that robust checks had been implemented to minimise the risk of people's medicines not being administered in accordance with prescription guidelines. However, during our inspection we found that people's medicines were not always managed safely. There were ineffective measures in place to ensure people received their medicines safely whilst staff training was updated. This meant that the provider had failed to ensure the action plan implemented following our last inspection had led to improvements regarding the administration of people's medicines.

During our last inspection in August 2017 we requested details of people who had asked not to receive night time checks to assure ourselves that risk management plans had been completed. The manager of the service had informed us that this did not apply to anyone using the service and that everyone received welfare checks during the night. However, during this inspection we found this information had not been accurate. As reported in the safe domain, one person was reported to have requested not to have welfare checks at night. The provider had not followed their policy to ensure that adequate risk management plans were in place.

Quality assurance systems were not always effective in identifying concerns and ensuring continuous improvement. An audit completed in April 2018 had identified that activities in the Oaks were not of the same standard provided in the assisted living areas. This was detailed on the service improvement plan and due for completion the week following our inspection. We found there was a continued lack of person centred activities in the Oaks for people to take part in. Staff told us they did not feel any improvements had taken place. In addition, quality audits had not identified concerns regarding the lack of dignity and respect shown to people living in the Oaks during mealtimes. Whilst efforts were being made to recruit permanent staff to the team, this had not been consistently successful. Whilst recruiting for permanent staff the provider had not taken steps to ensure the care provided to people throughout the service was not affected by the high use of agency.

Records did not contain sufficient detail to ensure people were receiving safe and effective care. As reported within the Safe area, risk management plans did not always provide sufficient detail for staff to follow and MAR records were not always accurately completed. In addition, we found that fluid and nutrition charts were not always fully completed and monitored. We observed that two people did not eat their lunch on The Oaks. However, records indicated they had both eaten their whole meal. One person's fluid chart stated they had not consumed their target fluids on six days from the previous week. This had not been monitored to ensure the person was encouraged to drink more. The persons nutritional chart had not been completed on four occasions over the previous week. Records showed that none of the people referred to had experienced weight loss or consequences from low fluid intake. However, the lack of accurate recording meant people were at risk of their well-being not being accurately monitored.

The failure to effectively monitor the quality and safety of the service and to maintain complete and contemporaneous records was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not consistently ensured that CQC were informed of all significant events which had taken place. Following our last inspection, the provider had given reassurances that systems were in place to

ensure that CQC were notified of all significant events in a timely manner. However, on two occasions, the provider had contacted CQC as statutory notifications had not been submitted in line with requirements. Prior to the inspection we were informed by the local authority safeguarding team of a number of safeguarding concerns relating to altercations between people living at Rosebery Manor. There was no record of these incidents being reported to CQC to ensure we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

People had the opportunity to provide feedback on the service they received. A resident's forum was held on a monthly basis in addition to an activity forum and food forum. This gave people the opportunity to contribute to the running of the service and feedback on past events. Minutes of meetings showed that people received updates on any changes happening and were able to contribute their thoughts. The activities and food forums asked people for ideas and suggestions regarding future activities and menus. People told us they felt their ideas were listened to. One person said, "The forums, split for different things are good." Another person told us, "I suggested that the outside activities should have a walking distance (easy, medium and longer) so that people could choose with some knowledge of what was expected and this has been added to the information sheet. I hear from folk that it helps them." A third person said, "We asked for liver and bacon and now it's on the menu." Relatives also had the opportunity to attend meetings and add their feedback. The service also encouraged relatives to be involved in social events in order to develop relationships. The provider also completed an annual survey which gave people and relatives the opportunity to comments the service they received. The manager that no survey had been completed since our last inspection.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit statutory notifications in line with their responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care and activities in line with their needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that staff supported and engaged with people in a respectful and dignified manner

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to address and monitor complaints

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of skilled staff were deployed and that

staff received training and consistent supervision to support them in their role

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure risks to people's safety were monitored and reviewed and that people received their medicines safely

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to effectively monitor the quality and safety of the service and to ensure that complete and contemporaneous records were maintained.

The enforcement action we took:

Warning Notice