City Health Care Limited

Rossmore Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 October 2017 and was unannounced. At the last inspection in March 2017, we had concerns in multiple areas. The service was rated inadequate and placed in special measures. The provider sent us an action plan and weekly updates so we could monitor progress. At this inspection, we found improvements had been made and the service is no longer in special measures. However, we are unable to rate the service higher than 'Requires Improvement' overall as to do so needs evidence that improvements continue and are sustained; we will continue to monitor the service and will check out improvements at the next full comprehensive inspection.

Rossmore Nursing Home provides personal and nursing care for up to 56 people. The service is accommodated in a series of converted, large, terraced houses in a residential area of Hull, close to amenities and public transport; there is on-street parking available. The service has 17 placements for people who have had a stroke and who require therapy input to assist their rehabilitation. There is a separate building in the grounds of Rossmore Nursing Home specifically for stroke rehabilitation and an adjoining house to this has been purchased to extend the area. There are eight step-down placements for people who require an interim service following discharge from hospital until a package of care can be arranged for them in the community. The remaining 31 placements are for people who require on-going residential or nursing care. There is a large sitting room, a small seated area and a dining room on the ground floor. There is a mixture of single and shared occupancy bedrooms on the ground and first floors; the upper floors are accessed by a passenger lift, a stair lift and stairs. There are bathroom and shower facilities on both floors.

At the time of the inspection, there were 12 people using the stroke rehabilitation service, 15 people admitted for residential care and four people requiring nursing care. The hospital step-down beds had been closed to admissions since the last inspection.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been in post for the last few months and was undergoing registration with the Care Quality Commission; their interview was due to take place on the day of the inspection. We liaised with our registration team to rearrange the interview until a later date to ensure the manager could focus on the inspection. As the registration process has not been completed yet, the manager will be referred to throughout the report as 'the manager'.

We found there had been improvements with the overall management of the service and also regarding governance from directors. We saw documentation which highlighted the directors had made visits to the service, spoke with staff and people who lived there, looked at records and checked on the progress of action plans. Staff confirmed management had improved and said they could raise concerns with directors if required. We found people had been informed of the changes underway and those planned for the future.

There had been a change in the structure of the therapy service, which at the last inspection was provided by staff from a local hospital trust. However, the therapy staff were now part of the provider's organisation and measures were being put in place to begin team-building, improve communication and address the issues with disjointed working between care/nursing staff and therapy staff, which was found at the last inspection.

The quality assurance and monitoring system had improved. This consisted of audits, checks, meetings and surveys. The audits and checks had highlighted shortfalls and we saw action had been taken to address them or measures were planned. There was refurbishment and redecoration of communal areas and several bedrooms underway which when completed will improve the quality of the environment for people who live there and staff who work there.

The environment was much safer and cleaner. Since the last inspection, there had been a deep clean of all areas and equipment used in the service. All unused equipment had been disposed of and sluice rooms and store rooms were made inaccessible when not in use. People who used the service had all had their moving and handling needs assessed to ensure the availability of the correct equipment; this had resulted in new items being purchased. There were systems in place to check bedrooms and toilets to ensure these remained clean and ready for use.

Staff knew how to safeguard people from the risk of harm and abuse. There were safeguarding procedures to guide staff and most had completed training. The manager was aware of which members of staff still required training or updates and this had been planned. In discussions, staff were knowledgeable about the different types of abuse and they could describe the signs and symptoms that would alert them. They knew how report concerns and the manager was aware of their responsibilities in referring issues to the local authority safeguarding team. People had individual risk assessments completed which provided information to staff in how to minimise risk. Following a visit by the local authority commissioning team, Personal, Emergency, Evacuation Plans (PEEPs) had been completed. These provided guidance to staff and professionals should people need to be evacuated in emergency situations.

We found people's health care needs were met. They had access to a range of community health care professionals when required. We saw there were safe systems in place to manage medicines and people received them as prescribed. However, there was some concern highlighted regarding the checking arrangements for ensuring medicines were correct on discharge. This was discussed with the manager to address. People who used the stroke service received therapy to assist their rehabilitation from physiotherapists, occupational therapists and speech and language therapists; there was daily medical cover for them and social work support when discharges were planned.

People's nutritional needs were met and menus provided them with choices and alternatives. There were also special diets when required. Since the last inspection, there had been errors made regarding people being given food and drinks of the wrong consistency and systems had been put in place to monitor this. Staff had received supervision and signs were in bedrooms to remind them to check the consistency of fluid required before giving people drinks.

At the last inspection, we found there was an inconsistency in ensuring people's capacity was assessed and that any decisions made on their behalf in their best interest, were recorded. Some progress had been made in these areas. However, there were still more assessments and decision-making records to complete for people's specific restrictions or to ensure the requirement for a deprivation of liberty safeguard. The deputy manager was auditing care files to ensure this was completed quickly. Staff were clear about the need to obtain consent prior to carrying out care tasks.

People had assessments of their needs completed and care plans formulated to guide staff. The care plans were being updated following advice from dementia care mappers to ensure these reflected people's individual needs and to guide staff in how to deliver care in line with their preferences. The provider had commissioned the dementia care mappers to visit the service and observe staff interactions with people living with dementia. Their observations and advice to staff had resulted in a more person-centred approach and an improvement in the quality of life for some people.

There was a range of activities provided to people. The activity coordinator had weekly plans and recorded when people participated in them. One person told us they would like to have more activities for younger people. This was mentioned to the manager to address.

Staff were recruited safely and in sufficient numbers to meet people's needs. There were designated staff for the stroke service and the provider was in the process of recruiting a stroke specialist nurse.

Staff had access to training relevant to their roles. There was a training plan which identified the courses they had completed and when updates were due. Shortfalls in training had been identified and planned. Staff also had supervision meetings to discuss issues and there were formal observations of their practice.

The provider had a complaints procedure which was on display in the service. People told us they felt able to complain if required and staff knew how to manage complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. We saw improvements had been made in this area, however, we could not rate the service higher than requires improvement for 'safe' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Staff knew how to protect people from the risk of abuse and harm. There were policies and procedures to guide staff in managing safeguarding concerns. People had individual risk assessments completed. These ensured staff had the information they needed to minimise the potential for accidents and incidents.

People received their medicines as required. There were systems in place to ensure the safe management of medicines.

Staff were recruited safely and in sufficient numbers to meet people's needs. The recruitment of a specialist stroke nurse should help to alleviate concerns that care staff need more time when supporting people with rehabilitation following a stroke.

The service was clean and tidy.

Is the service effective?

Requires Improvement

The service was not consistently effective. We saw improvements had been made in this area, however, we could not rate the service higher than requires improvement for 'effective' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

There remained an inconsistency in the application of mental capacity legislation. Staff knew how to gain consent prior to delivering care tasks.

People's nutritional needs were met. Menus provided them with choices and alternatives. A system had been put in place to increase communication between staff about people's special dietary needs.

People had access to a range of community health care professionals when required and those people who had experienced a stroke had a good therapy service.

Staff had access to supervision, support and a training programme to ensure they gained the skills and experience required to support people. Gaps in training had been identified and steps taken to plan courses.

Is the service caring?

Good

The service was caring.

There have been improvements made in the way people's privacy and dignity had been promoted. People told us staff respected their right to privacy and helped them to maintain their independent living skills.

The staff approach was described as caring, friendly, helpful and empathetic. We observed staff were attentive to people's needs.

Staff respected the need for confidentiality when discussing people's personal information. All personal information relating to people who used the service or staff was stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. We saw improvements had been made in this area, however, we could not rate the service higher than requires improvement for 'responsive' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Time and resources had been made available to ensure enhanced assessment and care planning processes were developed. Staff had improved the individualised care provided to people living with dementia.

People had access to a range of meaningful activities.

The provider had a complaints procedure and people felt able to raise issues knowing these would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. We saw improvements had been made in this area, however, we could not rate the service higher than requires improvement for 'well-led' because

to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Directors had more structured oversight of the service. They visited frequently and checked action plans to make sure improvements continued to be made.

There had been a change in manager since the last inspection. Staff told us management support had improved and they felt able to speak to them about concerns.

Audits and checks took place which enabled shortfalls to be identified and action taken in a timely way. These measures had helped to improve the quality of the service received by people.

Rossmore 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 checked 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 10 and 11 October 2017 and was unannounced. The inspection team consisted of one adult social care inspector on the first day and two on the second day. We were accompanied on the second day by an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance their experience was caring for an older person living with dementia.

Prior to the inspection, the 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. We used the PIR to help in the planning of this inspection. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We attended a multi-disciplinary team meeting on the stroke unit to observe how care, therapy and discharges were planned and also to see how staff worked together, and with other agencies, for the people who used the service. We spoke with seven people who used the service and four of their relatives. We received feedback from five other relatives. We spoke with the manager, two directors of the service, the deputy manager and five care workers, one of which was a team leader and another who was a senior. We also spoke with an agency care worker, the cook and the activity coordinator. We spoke with health and social care professionals which included three members of the stroke team and a dementia care mapper.

We looked at seven care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 25 people, daily notes of care provided and monitoring charts for behaviour, nutritional intake and weights. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included five staff recruitment files, training and supervision records, the staff rota, menus, minutes of meetings with staff and people who used the service, shift handover records, quality assurance audits and complaints management. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in March 2017, we had concerns about a number of issues in this key question. These included breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding safeguarding people from abuse, the provision of safe care and treatment, safe management of medicines, cleanliness and infection control, and staffing. During this inspection, we found improvements in all these areas and the provider was compliant with the regulations.

People who used the service told us they felt safe living there and staff looked after them well. Comments included, "They all love you; they won't let me fall and I get on well with everyone", "Yes, I always feel safe", "Yes, there are people around you all the time; I have the red buzzer [call bell] on my wheelchair now", "It's [staff response] not long really when you press the bell" and "Yes definitely; they look after me well."

There were comments from some people that call bell response times could be improved. This was mentioned to the manager to check out with people the length of time they felt they were waiting and also to check the new call bell system which recorded response times. We monitored call bell response times throughout the day and recorded these were between one and four minutes. There was one occasion when the response time was eight minutes and we spoke with the person about this. They advised staff would have known they had used the call bell to request assistance with a cigarette and they were happy with the response time.

Relatives said, "There are plenty of staff and security is good", "They feel safe and secure and never complains of feeling intimidated or frightened" and "Staff are in and out [of the bedroom] all the time." One relative was concerned that the use of agency staff meant there was inconsistent care for their family member. This was mentioned to the manager to discuss with the relative.

Most staff had received safeguarding training although there were a small number of staff still to complete it. We had received information in a timely way regarding any incidents which affected the safety and welfare of people who used the service. The local authority safeguarding team had also been informed as required. The manager knew how to report safeguarding concerns and told us they would seek advice from the local authority safeguarding team as required. In discussions with staff, they were able to describe the different types of abuse, the signs and symptoms that would alert them to concerns and how to pass on the information so it could be referred to the appropriate agencies. Staff also confirmed they were aware of the provider's whistle blowing procedure. The administrator described the system in place to ensure people's personal allowance was managed safely; the system helped to protect people from financial abuse.

We found risk was managed more effectively and safely. Items of equipment that had cluttered the service and made trip hazards had been removed, as had several unsafe bedrails. Sluice rooms remained locked when not in use and inaccessible to people who used the service, and there was clear access to fire extinguishers. During a visit by the local authority contracts and commissioning team, they found limited fire risk management plans regarding how people were to be evacuated in emergency situation; this has been addressed. People had individual risk assessments completed for areas of concern such as nutritional

intake, swallowing difficulties, fragile skin, falls, moving and handling and anxious or distressed behaviour. Other risk assessments included smoking, infections, and the use of equipment such as bedrails. The risk assessments helped to better inform staff on how to support people and minimise the potential for incidents and accidents.

Medicines were stored securely and at the correct temperature. We found people had received their medicines as prescribed and stock was controlled so people did not run out of them. There had been an occasion when a repeat prescription had been delayed by two days but we saw this had been followed up by staff. Records showed staff had received training in medicines management and had their competency assessed. People told us they had no concerns regarding their medicines and received them on time and as prescribed.

There were some minor recording issues which were discussed with the manager to address with staff. These included ensuring protocols were in place for all medicines that were prescribed 'when required', 'as directed' or with a variable dose. A large number of protocols were in place but some had been overlooked. Following the inspection, we received information that medicines were not countersigned as correct when people were discharged home. We raised this with the manager to address with staff.

We found there was sufficient staff on duty to meet people's needs. At the time of the inspection, there were 12 people admitted for rehabilitation following a stroke. There were four care staff and a team leader to support these people during the day; four days a week there was an additional member of staff for four hours. There were some comments from care and visiting therapy staff that more staff time to support people with rehabilitation skills was required as this could be a time-consuming process. We spoke with two directors of the service and they confirmed a full-time specialist stroke nurse had been recruited, which would hopefully resolve the issue. There were also plans to improve the 'stroke patient's pathway'. This included community stroke nurses introduced to people and involved in their rehabilitation whilst they were still using the service rather than waiting for them to be discharged home.

In the main unit there were 19 people; four people had nursing care needs and the remainder had residential care needs. There were sufficient nursing and care staff on duty day and night to meet their needs. The deputy manager, also a qualified nurse, and the manager worked Monday to Friday. There were ancillary staff for the provision of activities, catering, domestic, laundry, administration and maintenance. This meant that care staff could focus on care tasks.

There was a safe system of recruitment. Staff had full employment checks carried out prior to them starting work. These included an application form to assess gaps in work history, references, an interview and a Disclosure and Barring Service (DBS) check. The latter identified any previous police convictions and helped the provider make safe recruitment decisions. Qualified nurses had their registration record checked to make sure there were no adverse conditions that would prevent them from working at the service.

There were improvements in hygiene and cleanliness of the service. Since the last inspection, the service and equipment had been deep-cleaned. Redecoration was underway in the sitting room and dining room, and several bedrooms were being refurbished. These areas were inaccessible to people who used the service. New flooring was being laid in the sitting room, dining room and small seated area. These areas looked fresh, light and clean. There was an odour in one of the bedrooms but the manager was aware of this and measures were underway to address it. Staff had personal, protective items such as hand sanitiser, gloves, aprons and paper towels to help prevent the spread of infection.

Equipment used, such as hoists, the lift, and electrical and gas appliances was serviced and well-

maintained. There was a business continuity plan for emergency situations.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in March 2017, we found some concerns in this key question. These included breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding consent and the use of mental capacity legislation, and also people not receiving timely heath care. There had been improvements in both these areas and the provider was compliant regarding timely health care. There was more work to be done to ensure that where there was doubt about a person's capacity, this was properly assessed and best interest decisions recorded for restrictions in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw a capacity assessment and best interest decision record for a person who required bedrails and a sensor mat. These were completed appropriately. The deputy manager was working through each person's care file to ensure they were in place for all restrictions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the provider was working within the principles of the MCA for people who used the service. Applications for DoLS had been submitted to the local authority and were awaiting assessment. However, it was unclear if capacity assessments had been completed prior to the application being made for each person. There was a capacity assessment in the paperwork used by the service and for some people this had been completed. The manager is to audit the DoLS applications to ensure capacity assessments are in place for each person.

Staff had a good understanding of the need to obtain consent prior to care tasks being carried out. In discussions, they described how they gained consent by asking people their permission, providing explanations before carrying out tasks and supporting people to do as much as possible for themselves. People spoken with confirmed they could make their own decisions and choices within the limitations of their health needs. They said staff asked their consent before carrying out tasks. Comments included, "I say if it is the right thing to go ahead and do", "They ask, 'is it alright if.' and I tell them" and "If I say 'no' that is the end of it." A relative said, "When they change them, they ask if it's okay."

People who used the service told us staff looked after them well and ensured they accessed health professionals when required. Comments included, "If you are poorly a doctor comes, that is all; there are no problems", "I see the doctor now and again and I see a district nurse", "The physios are very good" and "I've seen two doctors since I've been here and the physios every day." Relatives said, "The doctor's in there with them now; I feel they are in safe hands", "I visit every day and they are always clean shaven; they get regular physio so I am very happy", "The change since they have been here is phenomenal" and "They were using a hoist when they came here and now they are going home."

Records showed us people had access to a range of community health care professionals and staff contacted them when they had concerns about people. In discussions, staff were able to describe how to prevent pressure ulcers from occurring and how to recognise the early signs and symptoms when a person had a urinary tract infection. A health professional told us there had been an improvement in staff completing monitoring charts.

The environment and lay out of the facilities was not completely suitable for everyone who may require a stroke rehabilitation service and this was considered during the assessment process. It was recognised that this was difficult to resolve as Rossmore Nursing Home was the only stroke rehabilitation service in Hull. We were told that the narrow corridors could not accommodate people who required wider wheelchairs. The provider had acknowledged this and one of the directors told us they were looking at how this could be resolved with more appropriate facilities available for those people with specialist mobility needs. The house next to the external building used for stroke rehabilitation had been purchased by the provider with the view to increasing space for treatment and support for people with their activities of daily living in preparation for discharge home.

The dining room had been under refurbishment for the last week so people were eating their meals in their bedrooms. People told us they liked the meals provided to them. Comments included, "The food is good and the carers are pleasant", "They know what I don't like", "The food is brilliant; I love the porridge and I choose whatever I want", "It's very good, fresh and well cooked" and "Brilliant; they are all good chefs. I asked for pasta and he did me spicy chicken pasta; they offer lots of things." Relatives said, "There are no complaints about food" and "They are very strict with pureed foods but they can have a banana now."

The menus provided people with choices and alternatives and special diets were catered for, which included textured meals, low sugar and high calorie meals. We saw people had their nutritional needs assessed as part of their admission process; any risks such as swallowing difficulties or poor intake were highlighted and these were kept under review. People were weighed in line with risk assessment status, either weekly or monthly. Those people at nutritional risk had their food and fluid intake monitored. The cook had a list of people's dietary needs.

Due to several errors and near misses when people in the stroke unit had received meals of the wrong texture, a checking system had been set up when meals left the kitchen. This had been partially successful and errors had been reduced, however, there had been a recent occasion when a person was served fluid at the wrong texture. There was no harm to the person and staff have been reminded to be vigilant when giving drinks to people with known swallowing difficulties. We observed bedrooms had reminders for staff to check the required consistency of fluids. We were told there had been incidents when a communal tin of thickener had been used. Thickeners were added to fluids to ensure an appropriate texture for people with swallowing difficulties. As there were different types of thickeners prescribed on an individual basis, it was important that these were not used in a communal way. The manager confirmed this practice had ceased. Staff had received a targeted supervision session on the need for good communication about people's dietary needs in the stroke unit.

Staff received training, supervision and support to enable them to feel confident when supporting people who used the service. The training records indicated that all staff had undertaken a basic induction course and most had completed the provider's more specific induction. The manager showed us a four-week induction pack which had been formulated for new staff employed from now on. This had a section to record observations of practice and competency in specific areas such as accurate record keeping and supporting people to promote their choices and preferences.

There was some outstanding training for staff but this had been identified and planned, for example, safeguarding, the Care Certificate, catheterisation and basic food hygiene; updates of training had also been highlighted. Training in physical intervention and the use of restrictive holds was still to be sourced. Staff in the stroke unit told us they received instruction from therapy staff which they felt was very useful. For example, regarding the need for textured diets and how to position and manoeuvre people safely. Some comments from therapy staff highlighted the need for more stroke rehabilitation training for care staff. This has been acknowledged by the provider and the training record indicated level one stroke training had been planned for staff. There would also be support for care staff from a newly recruited stroke specialist nurse.

People spoken with all said they thought the staff knew how to look after them and gave the following examples, "I had a bath today and they used the bath hoist okay", "They are now [skilled]; they have had hoist training and got a lot better" and "Yes they can deal with my catheter." Visitors were very complimentary about the stroke therapy their relatives had received.

Staff confirmed they received supervision and felt supported by the manager. Comments included, "Management is good; you can speak to either the manager or deputy", "Confidentiality is maintained now", "I feel more supported now; you can go to [Manager's name] and speak up about anything" and "[Manager's name] is brilliant; we work really well together and I'm included in everything."

Good

Is the service caring?

Our findings

At the last inspection in March 2017, although people were complimentary about the staff, we had concerns that people's privacy, dignity and at times confidentiality could be compromised due to staff actions. We found there had been improvements in this area.

Continence products were stored properly and it was clearly identified on the box who they belonged to. This meant staff only used continence products for the people they were prescribed for. Curtain fixtures had been replaced and one person who had a privacy issue had been relocated to a different room and a voile curtain provided at the doorway. This ensured staff could discreetly monitor the person and they were afforded additional privacy. People had their own toiletries clearly labelled and stored in their bedrooms; toiletries stored in communal bathrooms had been removed. White boards in shared bedrooms that recorded personal information had been removed and this information was held more discreetly.

At the last inspection, there were also issues with the lunchtime experience for people which was not the sociable, pleasant time it should have been. At this inspection, we were unable to monitor this as the dining room was out of action due to refurbishment and everyone had their meals in their bedrooms. We spoke with people about this and they were understanding of the need to restrict access to the dining room and were looking forward to the time when this could be used again. People had been kept fully informed about the redecoration and refurbishment timescales. We observed people had meals taken to their bedrooms on a tray and the plate was covered to help keep the food warm.

People who used the service gave positive comments about the staff approach and said they respected their privacy and dignity. Comments included, "I love to be on my own and I'm happy in my room", "I have a laugh with them, all alright", "There is plenty to eat and drink but I like my lager best so staff bring me it", "It's wonderful; everyone is friendly", "They are all helpful; it's all good", "It's better than hospital and the days go quicker" and "Its good, they look after you."

Relatives said, "They are all friendly; everything is fine and they keep me up to date", "They are friendly, warm and very caring; for the families too", "My husband is being cared for very well and the staff cannot do enough for them to feel at ease during this very difficult time. We are included in progress meetings and consulted about the next stages of recovery", "Staff are kind, caring and show empathy" and "There are no problems with the staff; they are friendly and don't make it look a chore which means he doesn't mind ringing the buzzer. They answer queries and keep me informed; I can't praise them enough."

In discussions with staff, it was clear they knew people's needs well and how to look after them. Staff described how they ensured people's privacy and dignity was maintained and how they helped them to be as independent as possible. The said, "We always cover people up during personal care, knock on doors and keep doors and curtains shut", "We explain what we are doing, promote independence and respect people's choices" and "We have personal care signs for the doors so staff know not to enter. We realise that people had a life before their stroke."

We observed staff were attentive to people's needs and requests. When speaking to people, staff made eye contact, approached them in a friendly way, and sat and listened to what they had to say. We observed staff explained what they going to do before carrying out tasks such as moving and handling people, adjusting clothing, giving medicines or supporting them to eat their lunch. Throughout the day, we saw staff were friendly, smiled at people and were unrushed.

We saw bedrooms all had call bells for people to summon staff and there were drinks available. Some bedrooms were nicely personalised where people had brought in pictures, photographs and ornaments to make it look homely. The bedrooms used for people receiving stroke rehabilitation were more practical as they were for short-term use. All the shared bedrooms had privacy curtains dividing the two beds.

People were provided with information about the service and what they could expect in a service user directory and statement of purpose. The activity plan and menu was provided to each person on a weekly basis. There were notice boards for information although some of these had been removed prior to the inspection due to the redecoration work underway. The manager told us they would be replaced when the work was completed. People also told us they had been informed about the building work and how long this was expected to take before completion.

We saw staff were aware of the need for confidentiality and conversations with health professionals or relatives were conducted in private if required. Phone calls were made in offices to ensure personal information was not overheard. We observed staff closed an office patio door, which led to a communal courtyard, when discussing personal information.

Computers were password protected and the provider was registered with the Information Commissioners Office, which was a requirement when records were held electronically. People's care files and medication administration records were held in lockable cabinets/rooms and staff personnel records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in March 2017, we found some concerns in this key question. These included breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding the delivery of person-centred care and working with other professionals when care and treatment is shared. Also people admitted into the hospital step-down beds had not received a thorough assessment and care plan documentation was missing. The hospital step-down beds were used for people awaiting provision of care in the community whilst medically fit for discharge. There were also concerns about other assessments and care planning for people in the stroke unit. Following that inspection, the provider voluntarily agreed to stop admissions to the step-down beds until improvements were made. This has enabled the manager to look at the overall assessment and care planning process, the delivery of person-centred care and improve the working relations with therapy staff. We found improvements had been made in these areas and the provider was compliant with regulations.

People who used the service told us staff were responsive to their needs. Comments included, "I'm happy with all the care I have had", "I'm happy with the care", "They talk about my care plan; the physio has mentioned this" and "The care is good."

People admitted to the service had assessments of their needs and care plans developed in order to guide staff in how to support people in the way they preferred. New personal profiles had been completed for some people and these contained lots of information about preferences and routines; this was an improvement since the last inspection. The deputy manager told us they were updating every person's care file so they contained the new documentation. The information enabled staff to see the person as an individual with a rich history and not just as a recipient of care tasks. The manager told us they also received assessments completed by the local authority.

People admitted to the stroke service had separate assessment and care plan documentation. There were two types of care plans and the manager told us these will eventually be synchronised. People's medical files were sent to the service from the hospital to assist in the assessment, care plan formulation, review and discharge planning process, although staff said there could be a short delay in receiving them.

Some of the care plans we looked at were detailed and others less so. For example, some care plans for people with diabetes had lots of information whereas others needed more information about acceptable blood glucose ranges and what rescue action to take when required. The deputy manager told us that updating the care plans was part of the general care file update. Staff spoken with knew people's needs and said they had read care plans. The care plans we saw showed they had been updated when changes occurred.

We saw the provider had commissioned a local authority dementia care mapper to spend several weeks in the service observing staff approach to specific people living with dementia, some of whom had behaviours which had been very challenging to staff and other people. The observations they made and the advice following this had resulted in a change in staff practice and approach and the delivery of more person-

centred care. The dementia mapper said this had made a significant difference to the care provided to people and the quality of life they had. For example, one person had behaviours that caused anxiety and distress for them and at times injuries to staff. The dementia mapper said, "Staff members have a better understanding of [Name's] communication and challenges. [Name] is now clean shaven [they had previously declined support], has an improved quality of life and is now communicating and is alert. They are also provided with a selection of breakfast options rather than just porridge."

The dementia mapper also described a situation when a person had longstanding, recurring sore areas to their knees but repositioning advice and a change in equipment has resolved the issue for them and improved the quality of their life. They also described a situation they had observed when staff had played a person's favourite music during personal tasks. They described staff interactions as producing a positive mood throughout and the person happily complying with care tasks.

We saw there had been a change in working relationships between staff at Rossmore Nursing Home and the multidisciplinary team (MDT) in the stroke service. Rather than having a disjointed approach to the delivery of care and therapy, moves had taken place to ensure a joint team approach. Office arrangements had been reorganised which meant there was more interaction between the different groups of staff. Therapy plans were held with care plans to make them accessible to care staff. Community stroke nurses visited the service twice a week and supported with the writing of care plans. A health professional told us they had seen an improvement in the completion of monitoring charts, recording of people's weight and preparation for MDT meetings by the senior care workers. We observed part of a MDT meeting and saw the team worked together to review people's care needs, discuss therapy input and progress, and to plan discharges home.

There was a programme of activities organised and an activity coordinator employed five days a week to deliver them. During the two-week redecoration and refurbishment of communal areas, an additional member of staff had been available to support the activity coordinator in completing one to one activities for people in their bedrooms. The activity coordinator recorded who had participated in activities and whether they had enjoyed it. The programme of activities included dominoes, quizzes, bingo, group games, music nights, one to one sessions, hand and nail care and trips out to local facilities. Some people had attended Hull Fair and outings to The Deep [aquarium] and the coast. Up to seven people regularly attended 'Golden Leaves' which was an over 55's social club.

The activity coordinator said, "I go to see the client and I read their care plan and I ask them what they want to do" and "I find out their interests and what they can physically do." They described how they supported one person to attend an international supermarket to make specific food purchases and how they brought a 'taste of Hull Fair' [cinder toffee, candy floss and other foodstuffs] to people in the stroke unit. They also told us how they liaised with a local school so pupils could come into the service at times such as Christmas to meet people and sing carols. Comments from people who used the service were, "We have one to one's, questions and answers and I watch my television", "They play dominoes for my poor vision and it helps. We also have quizzes", "They did a music night; I would have liked to do more. I went home twice a week and I'm going home permanently tomorrow", "They do them but they are mainly for older people but I am happy with that" and "I don't do any; I don't like to leave my room." Relatives said, "They play board games with them in bed" and "They like watching their television and reading magazines."

The provider had a complaints policy and procedure, a copy of which was included in the statement of purpose and 'service user's directory'. This detailed who to refer complaints to, whose responsibility it was for investigating them and timescales for acknowledgement and completion. People who used the service said they felt able to raise concerns if required but none of them had any complaints. Comments included, "I would tell the wife; she would sort it" and "I would speak to the manager if I had any concerns." Relatives

told us, "I don't have any concerns", "I've raised concerns in the past; nothing serious and it was dealt with" and "I feel able to raise concerns about anything."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in March 2017, we found some concerns in this key question. These included breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding good governance and having up to date records. There was also a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 when we did not receive information as required about incidents that affected the safety and welfare of people. At this inspection, we found improvements had been made in these areas and the provider was compliant with regulations.

The manager was registered with the Care Quality Commission (CQC) for another service within the provider's organisation and was about to complete registration for Rossmore Nursing Home. They were aware of their registration responsibilities regarding sending notifications of incidents or accidents which affected the safety or welfare of people who used the service. We received these in a timely way. There was a deputy system at the other service which meant the manager spent most of their time at Rossmore Nursing Home. It was important this continued whilst improvements were made and to make sure these were sustained.

The manager had been in post since the last inspection and there had been multiple staff and other changes. Although this had initially caused disruption, things had settled down and staff told us they felt supported by management and able to raise concerns if required. They said that communication had improved and they saw the directors when they visited. We spoke to two directors of the service and they confirmed oversight visits to the service were much more structured. They recorded the dates and length of time of the visits, what records they looked at, which staff they spoke with and the action required to address any shortfalls. We had also received a comprehensive action plan and weekly updates in a timely way to evidence the progress achieved since the last inspection. We were told that some of the changes could have been managed more effectively and this was mentioned to the directors during feedback at the end of the inspection. However, it was acknowledged that because of the overall inadequate rating at the last inspection, change had to occur at a quick pace.

The manager told us senior management had been very visible in the service and supportive of decisions they have had to take. They described the culture of the provider as being open to suggestions, being focussed on people who used the service and ensuring they had a good quality of life. They also said the provider invested in staff, listened to them and involved them. They said, "The clients [people who used the service] come first – that is my mission" and "It's important I have well-trained staff, give them clear direction and keep them informed." The manager also spoke about the importance of improving communication between the three areas of the service [stroke rehabilitation, nursing care and residential care], as each area worked differently. There were plans to bring the staff team together and to look at team building.

Comments from care and therapy staff included, "It has been a bit upside down; lots of staff have left but it's getting better", "Morale was low but with positive feedback, it's getting better", "The inspection rating was very upsetting and it was hard to see the report but positives are now beginning to happen" and "Before if your face didn't fit you dare not speak up but I can go to [Name of manager] and feel more supported. We

have welcomed this new inspection as we have tried really hard to improve." Other comments were, "The environment is much cleaner and less cluttered", "Communication and joined up working has improved; people now have the correct equipment", "I meet regularly with the manager and we can sort things out", "There is still work to be done on team-building" and "Yes, I would have my mum here now."

People who used the service were aware of who the manager was and said they talk to them when required. Comments included, "It is better now; they listen to you. We have a new smoking hut which I asked for", "It's a lot cleaner since the new manager came and its being decorated; it is a lot better than it was" and "We have residents meetings; we discuss outings, day to day things and they tell us about anything that is going to happen."

Relatives commented on whether the service was well-led and said, "The service seems very good", "Yes, very well; friendly caring staff and management" and "I think the service is managed well."

Following the last inspection, an environmental audit had been completed and plans brought forward for the refurbishment and redecoration of the building. An infection control audit had also been completed which identified areas to be addressed. Action plans were in place for both these audits.

As part of the last inspection action plan, occupational therapists and physiotherapists assessed each person who used the service to ensure the correct moving and handling equipment was available; this resulted in new equipment being purchased. The National Early Warning Score system was introduced into the stroke service; this was used to help staff spot the signs when people's health care needs were deteriorating and records were monitored to make sure they were completed. The deputy manager had produced a monitoring form to record monthly clinical issues such as the number of urinary tract infections and pressure damage people had and was due to start using the form to document the action taken. Bedrooms were checked at least three times a day to ensure they were clean, tidy and contained the correct equipment. Other checking systems had been initiated for areas such as medicines management, first aid boxes, pressure relieving equipment and moving and handling equipment. These audits and checks helped to ensure the service was a safer place for people.

Recording of assessments, care plans and monitoring charts had improved. There was a system of auditing care files and checking monitoring forms, such as people's food and fluid intake, which helped to ensure more up to date records.

The provider commissioned dementia mappers to spend nine weeks in the service and to develop an action plan. This was to include their observations of staff practice and interactions with people living with dementia, liaison with families and other professionals involved in their care and support with person-centred care planning. This was a comprehensive piece of work and has already resulted in an improvement in the quality of life for some people.

There had been some surveys sent to people who used the stroke service since the last inspection and others were planned. The last survey was completed in September 2017 and the results had been collated but we could not see an action plan had been developed yet. The manager told us they would address this. Meetings took place where people could express their views. The last meeting took place on 20 September 2017 and the minutes were on display in the service.