

## Barchester Healthcare Homes Limited

# Rothsay Grange

### Inspection report

Weyhill Road  
Weyhill  
Andover  
Hampshire  
SP11 0PN  
Tel: 01264 772898  
Website: www.barchester.com

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#### Ratings

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

#### Overall summary

The inspection took place on 9 and 13 April 2015 and was unannounced. Rothsay Grange provides residential and nursing care for up to 60 older people, including people living with dementia, and those requiring respite and rehabilitation support. At the time of our inspection 41 people were living in the home.

The home consisted of three floors. The middle floor, known as Memory Lane, cared for people living with

dementia. The ground floor accommodated people with personal care needs. The top floor accommodated people requiring re-ablement and respite care, some of whom had long term care needs.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008

# Summary of findings

and associated regulations about how the service is run. The person managing the home was on leave at the time of our inspection. They were in the process of applying for the registered manager role with CQC, but subsequently left this post on 13 April 2015.

At the last inspection on 19 August 2014 we asked the provider to take action to make improvements to support staff to provide people with appropriate and skilled care, and ensure consent to care was gained following legal requirements. At this inspection we found these improvements had been made.

People were at potential risk of harm, because the provider's recruitment procedure did not robustly meet legal requirements. Although some checks, such as identity, criminal record checks and registration with professional bodies, had been completed satisfactorily, the provider did not ensure that gaps in applicants' employment history had been identified or investigated. Evidence of suitable conduct in previous relevant employment positions had not always been requested. There was a risk that staff employed would not be of suitable character to safely support people.

Staffing levels were not always sufficient to meet people's identified needs. Sufficient staff numbers, identified by the provider to meet people's needs, had not always been on duty during a four week period in March 2015. Staff had ensured this did not impact on people's physical support, but acknowledged that they were not always able to find sufficient time to meet people's social and emotional needs.

Checks and audits completed by staff and the manager had not always identified errors and omissions in people's records. There was a risk that people may not receive the care and support required to ensure their health and wellbeing. Medicines audits had not been updated to record progress towards completion. The provider's procedures had not been robustly implemented.

Staff demonstrated the provider's values, such as encouraging people's independence and treating people with respect. However, relatives and staff commented that the manager did not always display these values. At times they felt their concerns had been not been addressed satisfactorily, or were dismissed without consideration.

People were protected from the risk of abuse, as staff understood how to identify possible signs of abuse, and the actions required to protect people and report concerns. Risks had been identified, monitored and addressed appropriately to ensure people and others were not placed at risk of harm. Staff understood the actions required to protect people from harm and actions taken had been effective in promoting people's health and welfare.

People received their prescribed medicines safely. Medicines were stored, administered and disposed of safely. Administration records were complete, and included guidance for staff on 'variable' and 'as required' medicine doses.

Staff were supported to ensure they had the skills, knowledge and training required to effectively meet people's needs. Although supervisory meetings had not met the provider's requirement for quarterly review, staff told us there were effective measures in place to provide them with the support they required to raise and discuss issues and concerns.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), and followed these to ensure people were supported to give valid consent to their care. Where people were identified as lacking the mental capacity to make informed decisions about specific aspects of their care, appropriate actions had been documented to evidence that lawful consent to care was gained from those best placed to provide this.

People were supported to maintain a healthy diet. Where people were assessed to be at risk of malnutrition or dehydration, appropriate measures had been implemented to ensure people maintained a sufficient daily intake of food and fluids. People's health needs were effectively identified, and referrals to appropriate health professionals ensured they received the care they needed.

Staff were kind, respectful and caring. People sought staff support when they were anxious or confused, and readily chatted with staff. Staff were prompt to take actions to promote and protect people's dignity, and respected people's privacy when they chose to be on their own.

People's care needs had been discussed and assessed with them, or those important to them, prior to their admission to the home, and were regularly reviewed.

# Summary of findings

People's views and preferences were included in their plan of care. A range of activities were provided, and people's engagement with these was reviewed to ensure these activities met their preferences. People were satisfied with the care they experienced, and understood the process to raise concerns or complaints.

People, and those important to them, were able to discuss their views, wishes and concerns about the home, and individual care and support, during meetings and care reviews. Their views had influenced changes to menus.

The regional director was in the process of recruiting a new management team for this home at the time of our

inspection. They demonstrated the provider's values in their approach to people and staff. The provider reviewed information such as accident and incident reports to ensure appropriate actions were implemented to reduce the risk of repetition. Learning was shared across homes to develop understanding and shared learning for all managers. This promoted improvements to the quality of care people experienced.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

People were not protected from potential harm, as the provider did not complete all the recruitment checks required for new staff.

Sufficient staff had not always been on duty to meet people's identified care and support needs.

People were protected from the risks of abuse, as staff understood how to identify potential abuse, and the steps to take to report concerns.

People were protected against the risks associated with medicines, because appropriate checks, records and training ensured they received their prescribed medicines safely.

Risks specific to each person had been identified, and appropriate actions put into place to reduce the risk of harm. Checks and servicing ensured the environment did not affect people's safety.

Requires Improvement



### Is the service effective?

The service was effective.

Staff were supported to ensure they had the skills, knowledge and training required to effectively meet people's needs.

Staff understood and implemented the principles of the Mental Capacity Act 2005. People, or those important to them, were supported to provide informed and valid consent to their care.

People's dietary needs and preferences were met and regularly reviewed to ensure they were not at risk of poor nutritional health.

People were supported by health professionals to ensure their medical and health needs were effectively monitored and reviewed.

Good



### Is the service caring?

The service was caring.

People described staff as kind and caring. Staff were responsive to people's moods, and their actions demonstrated that they valued people's views and wishes.

People's dignity and privacy was respected, as staff took actions to ensure people were not placed in situations that would compromise their dignity.

Good



### Is the service responsive?

The service was responsive to people's needs.

Good



# Summary of findings

People's needs had been assessed. People's involvement in regular reviews ensured they received the support they required and wanted.

People and those important to them were able to raise concerns about or request changes to their care plans. Changes had been implemented in response to people's concerns and complaints.

## **Is the service well-led?**

The service was not well-led.

Staff and relatives described the manager as dismissive about some of the concerns they raised. The manager had not demonstrated the provider's values of accessibility and responsiveness.

Internal checks and audits had not always identified errors and omissions in monitoring charts or other records. There was a risk that people may not receive the care and support they required.

Surveys, meetings and reviews ensured people, relatives and staff had opportunities to influence the quality of the care they experienced.

**Requires Improvement**



# Rothsay Grange

## 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.

The inspection took place on 9 and 13 April 2015 and was unannounced. The inspection team consisted of two inspectors, including a pharmacist inspector, and an expert by experience with knowledge of people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports and notifications that we had received, and reviewed information shared with the CQC by commissioners of care. A notification is information about important events which the provider is required to tell us about by law. We had not requested a Provider Information Review (PIR) for this inspection. A 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.

Concerns had been brought to our attention regarding staffing levels and record keeping through information shared with the CQC, and the impact this had on people's planned care provision. This information was used to inform our inspection.

During our inspection we talked with eight people, and six relatives or friends of people living in the home. Some people living with dementia were unable to tell us about their experience of the care they received. We observed the care and support these and other people received throughout the day to inform our views of the home. We spoke with the regional director and regional operations manager, as well as three nurses, five care workers and other ancillary staff including those in catering and maintenance roles. We also spoke with a chiroprapist visiting the home on the first day of our inspection.

We reviewed eight people's care plans, daily care records, and charts documenting their specific care and support needs, such as maintaining hydration and re-positioning. We also reviewed 18 medicines administration records (MAR). We looked at eight staff files, including recruitment, training and supervision documentation. We looked at the working staff roster for four weeks from 2 to 29 March 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how people's and staff's comments and quality assurance audits were used to drive improvements in the service.

# Is the service safe?

## Our findings

People told us they felt safe with the staff, and one relative commented “I can leave here at night and know that she is in capable hands”. However, we did not find that all the provider’s processes ensured people’s safety.

The provider’s recruitment policy did not ensure that all the legal requirements to recruit staff suitable to support people would be met. It did not require a full employment history or identify the requirement for evidence of good character from all previous relevant employment in the health and social care sector. The manager had not considered the regulations to ensure that internal processes met legal requirements. Five of the eight recruitment files we reviewed did not show evidence of full employment history, with identification and investigation of any gaps. There was no evidence that character references had been sought from all relevant previous employment positions in health and social care. There was a risk that staff of an unsuitable character could be employed, as the provider had not completed robust recruitment checks.

The provider’s recruitment procedure did not ensure that staff employed were of good character. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other recruitment checks, such as proof of applicants’ identity, investigation of any criminal record, and registration with professional bodies, such as the Nursing and Midwifery Council, had been satisfactorily investigated and documented.

Concerns had been shared with the CQC prior to our inspection that staffing levels were not always sufficient to meet people’s identified or planned care needs. During our inspection, people told us there were usually sufficient staff available, although one person told us they sometimes experienced delays with staff responding to their use of the call bell. This had impacted on their personal comfort. We did not observe delays to call bell response during our inspection.

Staff told us they were busy, but were “Rarely short staffed”. One nurse told us that the requirement for one member of staff to be available in the communal lounge affected their ability to monitor people’s safety elsewhere. People sometimes chose to walk the corridors unaccompanied.

The nurse was concerned that fewer staff available to monitor their welfare may place them at risk of harm. They told us staff had less time to meet people’s social and emotional needs, as staffing had been reduced in response to fewer people requiring their care. Staff described how the use of agency staff had also impacted on people’s care, as they did not always know people sufficiently to be able to meet people’s emotional needs.

The regional director explained how they considered people’s identified needs and the design of the home when agreeing sufficient staffing levels for the home. They told us they had fully recruited to fill health care worker roles, but still relied on agency staff to meet nursing requirements. Where agency staff were used, they aimed to use agency staff with previous experience of working at Rothsay Grange, to provide a continuity of care for people.

We reviewed planned shift rosters and a pay log of claimed hours worked for a period of four weeks between 2 and 29 March 2015. The roster demonstrated the planned staffing levels, and had identified staff shortages, particularly for night and weekend shifts. The provider had approved use of agency staff to cover shifts where gaps had been identified, and at times had planned for staffing levels to exceed the requirement to meet people’s identified needs.

The hours log showed the number of hours actually worked on a daily basis. This indicated that there had been insufficient care worker staff to meet people’s identified care needs on five days, by a shortfall of between 11 and 31 hours daily during this four week period. Nurse hours had not met the required level on one day during this same time. This meant people may not have received the level of care or support they required to maintain their safety or wellbeing.

The regional manager told us that the hours log reflected staffing levels sufficient to meet people’s needs at a residency rate of 43 people. However, there had been approximately 39 people in residence during March 2015. This number varied due to people arriving or departing who required respite and re-ablement support. The regional manager told us staffing levels were reduced by approximately four care worker hours per person per day to reflect reductions in demands on staff support due to these variations. This did not demonstrate that people’s individual care needs had been considered in the reduction of staffing levels.

## Is the service safe?

People were at risk of inappropriate care and support, because sufficient numbers of staff had not always been deployed to meet their identified needs. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff listened if they had concerns about the care they experienced. If they requested a change of care staff because they were not comfortable with a particular member of staff, this was addressed by the unit manager promptly.

Staff received safeguarding training, and were able to explain indicators and symptoms of abuse. They understood the actions they should take if they suspected people were at risk of harm. The provider's and local authority's guide and procedures for identifying and reporting abuse were available in staff offices, and contact details were prominently displayed in staff areas for reference.

Medicines were stored safely, within their recommended temperature ranges. However, at the time of the inspection controlled drugs (CDs) were not stored within the available CD safe. CDs are prescribed medicines controlled under the Misuse of Drugs legislation. This could affect the safety of people, staff and others, as these drugs could potentially be accessed by those not authorised to do so. This was raised with staff and rectified during the inspection.

Information was available to support the administration of medicines. This included information about known allergies, 'as required' and 'variable dose' medicines, and whether people could indicate their needs verbally or by other means. People able to self medicate were identified. These measures ensured people were supported to access their required medicines safely.

We reviewed the records of two people who had been prescribed a medicine that required monitoring. The test results, dose changes and subsequent test dates had been entered in the staff clinical diary and monitored appropriately. We reviewed the agitation de-escalation plans for these two people. This explained how staff should support people when their anxieties challenged staff or others. Both plans contained details of triggers and non-drug interventions to be used prior to the use of the medicine. This ensured that effective actions, including safe and appropriate use of medicines, met people's identified needs.

Medicines administration was appropriately recorded. The administration of medicines was recorded within the Medicines Administration Records (MAR). Audits and nurse competency assessments ensured people's medicines were administered safely. Disposal of medicines records were accurately maintained. This protected people from unsafe administration of medicines, and the potential misuse of medicines.

People were protected from identified risks to their health and wellbeing. Specific risks to individuals, such as the risks of falling or choking, had been identified, and appropriate actions put into place to reduce the risk of harm, such as staff monitoring, changes to people's diets or regular health checks. Some people had been identified as forgetful or unable to use their call bells to request assistance. Their care plans noted people should be reminded to carry call bells with them where this was appropriate, and staff should carry out regular checks for people who chose to spend time alone in their rooms. We observed staff reminded people to carry call bells, and documented regular checks when people unable to call for assistance spent time alone. This demonstrated that staff were aware of risks specific to each individual, and understood and implemented actions to reduce the risk of harm.

Procedures and training ensured that staff understood the actions to take to protect people from harm in the event of emergency situations, such as fire or other events requiring evacuation of the home. Staff offices displayed emergency evacuation plans for people on each floor, noting the support they required to escape safely. Appropriate checks and servicing of equipment within the home protected people, staff and visitors from an unsafe environment. For example, certificates demonstrated that all required gas safety measures had been met, and annual tests found the home free of Legionella. Legionella is a water borne disease that can adversely affect people's health. The maintenance team completed regular checks, in accordance with the provider's and manufacturers' guidance, to monitor, identify and address issues within the home. This included testing water temperatures, checking emergency lighting, and carrying out portable electrical appliance tests. This ensured people and others were not at risk of harm due to faulty equipment.

# Is the service effective?

## Our findings

The provider had taken actions to address the concerns identified at our previous inspection in August 2014 regarding staff support and gaining lawful consent to people's care.

A nurse confirmed they had attended supervisory meetings with the manager on a quarterly basis, and conducted these for care workers within the same time frame. Staff described supervisory meetings as "Useful for airing concerns" and "Reviewing training needs". Not all the staff we spoke with recalled attending regular supervisory meetings, but all spoke positively about the support they received from senior staff and line managers. Comments included "I feel supported in my role", "We can talk about anything" and "I can raise issues with my mentor, and can go to the manager". Staff confirmed that they could request meetings to discuss individual concerns at any time. Line managers addressed concerns with staff promptly when these had been identified. This indicated that staff were suitably supported to raise and address concerns that may affect their ability to effectively meet people's needs.

Records indicated that 55 of the 72 staff employed at Rothsay Grange had attended at least one supervisory meeting in the last quarter of 2014, and all staff had regular planned supervisory meetings scheduled for 2015. At the time of our inspection, the regional director confirmed that 44 staff had attended supervisory meetings in 2015, and plans would ensure this was increased to meet the provider's policy of quarterly meetings and annual appraisals for all staff.

Staff described the provider's training as "Very thorough", "Excellent" and "Great". One care worker explained that training about dementia care "Really opened my eyes, and gave me an insight into their [people's] experience". A nurse described care workers as "Well skilled" and able to meet people's care needs effectively.

Staff completed training in topics required to promote the safety of people, staff and others. Staff learning was tested and evaluated through quizzes and discussions, to ensure staff understood the content of training. Regular refreshers were provided in accordance with the provider's training

policy. Staff spoke positively about the home's trainer, explaining how she supported them to attend, refresh and understand the training provided. Staff kept their required training up to date.

Training to understand people's specific care needs, such as wound assessment and dementia awareness was provided for staff. Nurses were supported through a preceptorship programme to maintain and develop their nursing skills, including managing people's palliative and pressure care needs. A preceptorship is a period of transition for newly qualified nurses, during which they are supported to develop their confidence and nursing skills. Where it was appropriate, there were records of competency assessments completed by mentors and managers, for example in mobilising people safely and administering medicines. This ensured that staff had the required skills and competency to support people safely and effectively.

New staff completed an induction programme in accordance with the Skills for Care Standards, a nationally recognised standard of care. They were required to complete training and shadow experienced staff before they supported people without supervision. Learning was assessed and evaluated during this period to ensure staff had the skills required to meet people's identified needs effectively.

Staff completed a mental capacity checklist to be assured of people's capacity to make decisions affecting their care, and when it was most appropriate to discuss people's care plans and needs with them. For example, some people living with dementia have variable mental capacity, and may find it easier to make their wishes known at specific times of day. The checklist and guidance for staff was included in people's care plans. Guidance prompted staff to seek people's consent where possible, and gave specific information about how people indicated consent.

Where people had been assessed as lacking capacity to make specific decisions about their care, the provider complied with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make specific decisions for themselves. Where people lacked capacity to make specific decisions staff acted in accordance with the principles of the MCA. This included an assessment of the person's mental capacity, discussion of their care needs in a best interests meeting with those best able to represent

## Is the service effective?

the individual, such as family, health professionals and care staff, and the decision reached. Staff understood that people should be supported to “Make simple day to day decisions”, and we observed people were supported throughout our inspection to do so. Staff confidently explained the principles of the Mental Capacity Act 2005 (MCA) to us, and how they implemented this to support and meet people’s wishes. Care plans reminded staff of the process to gain lawful consent to care, and recorded when relatives or others had legal authority to make decisions on a person’s behalf, such as a legal power of attorney for health and welfare.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a ‘Supervisory Body’ for authority to deprive a person of their liberty where this a necessity to promote their safety. The DoLS are part of the MCA and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. Where people had been deprived of their liberty to ensure their safety, for example through the use of door keypads to stair wells and lifts, applications for DoLS had been submitted by the provider to ensure these restrictions were lawful. The manager had submitted 19 applications to the local authority, but was awaiting confirmation that all of these had been granted. People with the mental capacity to understand the codes used could travel between floors unimpeded if they wished.

People appeared to enjoy their meals, and comments included “Absolutely delicious” and “The food is very nice

indeed, simple but very wholesome.” Assessments of people’s health identified those at risk of malnutrition or dehydration, and charts effectively documented the actions taken to support people to maintain a healthy and adequate dietary and fluid intake. Daily records of dietary and fluid intake were maintained for people identified at risk. Staff were informed at shift handovers when people had not met their target intake, to ensure staff coming on duty encouraged them to eat and drink sufficiently.

Staff were knowledgeable about people’s dietary requirements and ensured that specific needs such as a pureed or soft diet were met. Staff told us people’s dietary needs, allergies and preferences had been identified on admission, but were reviewed monthly to ensure changes were picked up promptly. This information was shared with kitchen staff to ensure appropriate meals were available to meet people’s needs and wishes.

The chiropodist was attending to people’s foot care needs during our inspection. They told us staff were helpful and cared well for people, and “Act on issues promptly”. Care plans documented that people were referred to health professionals in a timely manner when issues identified that this was required. For example, people had been referred to the GP because of identified weight loss or other indicators of poor health. Records of medical checks and tests showed that appropriate investigation of health issues had been completed. Advice from health specialists, such as the Speech and Language therapist, was included in people’s care plans, and implemented by staff, to ensure people received effective care to support their identified health needs.

# Is the service caring?

## Our findings

People told us staff were caring. One person described how staff joked and danced with her, and another commented “The staff are all very nice, kind and friendly”. People appeared relaxed with staff, and sought their company for comfort and reassurance when they were anxious or confused.

Relatives and visitors were welcomed throughout the day, and could choose to meet with their loved ones in communal areas or the privacy of people’s rooms. One person told us “My friends and relatives can drop in any time, there is no restriction and that’s very nice”. Staff often greeted visitors by name, which indicated that they knew people’s relatives well. A relative of a person receiving rehabilitation care told us “I wouldn’t think of moving her, all the staff always chat to her and she is definitely improving.”

Throughout our inspection we saw staff took time to chat with people even when they were busy. Staff told us they would like to spend more time doing this, as they realised how important it was for people’s wellbeing. Staff displayed affection for the people they supported through gentle touches and smiles. They encouraged humorous banter with people who welcomed this, and reassured those who were confused or angry. They understood how to diffuse situations that could escalate to behaviours that may challenge others. They treated people with respect, explaining the actions they took with people to promote their wellbeing and safety. The activity coordinator was not on duty on the first day of our inspection, but we observed staff engaged people in games and activities during the day to keep them entertained and occupied. One care worker told us “You have to put your heart and soul into this job”.

Staff ensured they did not make people feel rushed when they were supporting them. They allowed people time to consider their responses when they asked them questions. One person was struggling to hear a member of staff. The care worker wrote down their question. This ensured that the person felt their response was valued, and that the care

worker was assured that they understood the person’s wishes. When people were confused about meal choices, staff provided plated options to support people to make an informed choice.

The regional director and operations manager knew people by name, and stopped to have meaningful conversations with them during the day. They complimented people on their clothing and hairstyles, and joked and smiled with people. People appeared to appreciate these conversations, as they responded with smiles and interacted positively.

People told us staff respected their wishes. One person told us “I’m very firm with them if they don’t do what is needed.” Care plans evidenced that people had been involved in developing their care plans to ensure their care needs were known and met. A ‘resident of the day’ programme provided a formal monthly opportunity for people to discuss any issues or changes required to their planned care, although we observed people readily raised concerns with staff if they required assistance or were not satisfied with the care provided.

People’s life history, social, cultural and spiritual wishes were included within people’s care plans. This ensured staff were informed of people’s preferences when they were unable to communicate this verbally. One nurse confirmed “We have to use different methods of communication. We know our residents, and know when they are unwell”. Staff were responsive to indicators that people may be restless, in pain or uncomfortable, and took prompt actions to address these.

Staff respected people’s privacy. They knocked on people’s doors and waited to be invited in. Staff ensured doors were closed before providing personal care, so preserving people’s dignity. One person came in from the veranda to sit in the dining room at lunchtime. They were in a state of undress, in response to the warmth of the sunshine outside. Staff promptly supported this person to maintain their dignity, and suggested they escort them to their room to dress in clothing that would be more comfortable. This ensured this person was treated with respect, and followed their wishes whilst maintaining their dignity.

# Is the service responsive?

## Our findings

One nurse told us management were “Strict on completing observation charts”, and a care worker told us the staff were “Spot on” with managing conditions that may affect people’s health and wellbeing. Daily monitoring charts demonstrated that staff were aware of actions required to monitor people identified with conditions that may place them at risk of harm. We reviewed charts such as food and fluid charts, hourly and half hourly observation charts, bed rail checks and re-positioning charts. We found these had mostly been completed in detail, although there were some instances where information could have been clearer. For example, it had not always been recorded which side people requiring re-positioning had been moved onto. There was a risk that people may spend more time in one position than was appropriate. People were re-positioned to avoid the risk of developing pressure ulcers. Documentation evidenced that the development of pressure ulcers had reduced in the home, and the people affected by chart gaps had not experienced pressure ulcers. This suggested that the actions taken in response to identified risks were effective.

Nurses took appropriate actions in response to accidents and incidents, such as referral to health professionals and changes to people’s mobilising support. A nurse explained how regular checks identified people at risk of weight loss, and ensured appropriate actions were taken to support them, such as referral to the speech and language therapist, changes to diet and monitoring of dietary intake. Once measures taken had supported the person to reach their target weight, staff continued to monitor their weight until they were assured a stable weight was maintained. Care plans evidenced that actions taken had been effective in identifying and addressing risks to improve people’s health. Actions taken in response to identified risks had been reduced or removed once it was identified that these were no longer required.

People and relatives confirmed that they had been involved in assessments of their care needs prior to their admission to Rothsay Grange. They told us this was a comprehensive assessment that considered their wishes and preferences as well as health needs. One person explained how an initial assessment had considered that their restricted mobility would be best accommodated on the top floor. However, once they had moved in staff had

recognised that their mobility was sufficient to move them to the ground floor, where they were able to join in with activities and trips unassisted. For another person whose physical needs indicated they may be better accommodated by a move to another floor, the care plan evidenced consideration of how this would affect their mental wellbeing. It was decided that the staff who currently supported them would be best placed to identify small changes in this person’s condition. Therefore the decision was taken for this person to remain on the floor where staff knew them well. This demonstrated that people’s changing needs were considered and responded to appropriately by staff.

Staff handovers between shifts were held on each floor, and a daily ‘stand up’ meeting was held for heads of department and units to support effective communication. The daily meeting ensured key staff were aware of people being admitted or discharged from the home, and any issues affecting the home, such as planned maintenance work. This information was cascaded to all staff. Unit meetings ensured all staff were aware of their roles and responsibilities, and any issues or appointments affecting the people they supported. For example, staff were made aware of who needed encouragement to maintain an adequate food and fluid intake, and who was supporting people with one to one care.

The ‘resident of the day’ programme ensured that each person was the focus of staff attention on a monthly basis. Visits by care, maintenance, housekeeping, activity and catering staff ensured people’s needs and preferences were reviewed at this time, and changes made to meet their wishes. One nurse told us “We chat with them about the care provided, and any concerns they have. They are honest in their feedback”. Care plan reviews considered people’s cultural, spiritual and social values, hopes and concerns. These were reviewed monthly or sooner when changes had been identified, and updated appropriately.

A relative told us they were impressed by the range of activities provided for residents, such as arts and crafts, musical entertainment and games. People and visitors played scrabble together, and staff played board games and indoor golf with people. A range of activities were planned for each month, including trips into the local

## Is the service responsive?

community. Church services were organised in the home, and a hairdresser visited weekly to do people's hair. Care plans included a review of the activities people participated in, to ensure these met their preferences.

People's comments had been considered when reviewing the menu at a meeting in November 2014. Requests for lighter and smaller meals, more choice and improved flavours had been responded to by the chef.

People and relatives told us staff were responsive to their needs and wishes. One person told us "There is nothing I'm not happy with, nothing to complain about, they are all very nice indeed", and a relative said "We have nothing but praise for the staff who are all very friendly and lovely to

both us and Mum. If I have any concerns they are dealt with as soon as I raise them". The chiropodist confirmed that problems in the past had been resolved, and "Residents feel listened to, and are happier now".

The provider's complaints procedure was available for reference in the reception area. A total of five complaints had been raised in 2015. These had been dealt with in accordance with the procedure, with evidence of investigation and appropriate response to the complainant. Three complaints had been resolved, and two were in the process of resolution, with meetings offered to the complainants to review the concerns raised, and seek a resolution. People and their families had sent the staff complimentary cards, and these were displayed in staff areas.

# Is the service well-led?

## Our findings

Daily checks of charts and 'resident of the day' forms, carried out by nurses, heads of unit and the manager, had not identified when charts had not been fully documented. For example, re-positioning charts did not always record the side the person had been moved to, and body maps used for topical cream applications did not fully document information such as the person's name or the product to be applied. Gaps in monitoring forms did not always clearly notate that these related to periods when these checks were not required, such as when people rested or were in communal areas. Checks implemented by the home were not sufficiently robust to identify errors and omissions. There was a risk that people may not receive their planned care, although we did not see evidence that people's health and welfare had been adversely affected by this.

The manager carried out internal checks and audits, and actions identified from these were consolidated into an action plan. The regional director had electronic access to this, and monitored progress towards completion. We reviewed medicines audits carried out in September and November 2014, both internally and by a community pharmacist. An action plan had been prepared in response to the findings of these audits, but these plans lacked evidence of updates or reviews that would indicate actions had been taken to address these issues.

Systems and processes used to assess and monitor the quality of people's care had not always been effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional director had asked an experienced manager from another of the provider's homes to review people's care plans at Rothsay Grange, to identify areas for improvement. We noted comments by this manager in individual care plans identified where information required clarification, updating or completion. For example, they had identified that one person's bi-annual care review was due in February 2015, but had not yet been scheduled. Staff responsible for these actions were aware of their responsibility to make these changes, and were updating records accordingly at the time of our inspection.

The provider's values were noted in the statement of purpose and staff handbook, and displayed in the manager's office for reference. These described a service

that respected and supported people's needs and wishes, accepted responsibility for actions and behaviours, and sought to encourage and develop people's independence and creativity. Induction training ensured new recruits were aware of staff responsibilities and rights. One nurse told us that "In the main they [managers] listen". They told us that staff lived up to the provider's values.

Staff displayed these values in the way they supported people, and a care worker told us the provider was "On the ball and lived up to the mission statement". However, staff did not always identify these values in those that held senior positions. Staff during and prior to the inspection raised concerns that specific instances of short staffing, caused by planned and short notice absence, had not been addressed appropriately by the manager, despite staff bringing this to their notice and requesting support. They told us that although this did not impact on meeting people's physical care needs, it meant staff did not have sufficient time to chat with people to provide emotional support and improve people's wellbeing. They told us the manager had been dismissive of their concerns.

A relative told us there had been "Several managers over my time in the home" and that the current manager was "Not too great". They had overheard them telling staff to "Go ahead and muddle through" when staff had raised concerns over a delay to a meal time, and stated that the manager tended to stay in her office rather than proactively addressing issues.

The manager in post at the time of our inspection left this post on 13 April 2015. Several staff commented on the number of managers who had managed Rothsay Grange over the past two years. This did not provide a consistent management presence for staff. A nurse told us they did not think managers had sufficient support from the provider, as the paperwork and processes could be "Daunting" for managers new to the post. This impacted on staff, as changes in management meant issues raised were not always dealt with. But they felt that the regional manager recognised the need for a stable management presence, and hoped "Next time will be different". They praised the provider's procedures, stating a previous manager had empowered the nurses to take control, but that "Had slipped". They told us "I love it here, I want to make it work, but we need a strong and consistent leader".

Once the regional director was made aware of these concerns, they took immediate action to address them.

## Is the service well-led?

They explained the actions taken to ensure people and staff would be supported with appropriate management, and to ensure the provider's policies and procedures were embedded in the home. This included the appointment of an experienced temporary manager in place until such time as a registered manager and clinical deputy manager could be appointed. A period of handover and probation would ensure the new management appointees were sufficiently supported to take on their roles.

Confidential records were stored securely in locked offices. Information was used appropriately to inform and update people's planned care records, and staff could access these for guidance to support people safely and effectively.

Accidents and incidents were documented by staff. Details recorded information such as the person involved, the location of the incident, time of day and other factors that may have affected the situation. This information was electronically recorded, and reviewed by the provider's regional management team to inform learning across homes, and to identify and address trends.

An annual survey and residents and relatives meetings provided opportunities for people to discuss issues of concern, and changes planned or requested. We did not

see evidence of these held in 2015, but the regional director told us the next meeting was planned for later in April 2015. Staff were available and responsive to people's and relatives' comments throughout the day. People were included in monthly 'resident of the day' reviews, and six monthly care plan reviews. This provided opportunities for people and those important to them to discuss issues and concerns.

Communication within the home, including shift handovers and daily 'stand up' meetings, unit diaries and communication books, ensured staff were kept informed, although some staff stated they would appreciate more detail, especially if they had been absent on leave. Staff meetings had been arranged, and minutes from previous staff meetings were displayed on staff noticeboards to ensure all staff were aware of the meeting content. One care worker told us meeting timings did not allow all staff to attend, and it would be useful to hold similar meetings at different times or on different days to accommodate staff shifts. They did not feel that issues raised had always been addressed effectively, as concerns they had raised regarding staff practice did not appear to have evidenced changes.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed <b>Regulation 19 (2)(a)(3)(a)</b> People had not been protected from the risks of inappropriate care and support, because the provider's recruitment procedures did not effectively ensure applicants were of good character. Satisfactory evidence of conduct in previous employment positions in health and social care, or supporting people vulnerable to abuse, had not always been identified or verified, and a full employment history, with explanation of gaps, was not always documented.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing <b>Regulation 18 (1)</b> People were at risk of inappropriate care, because the provider had not deployed sufficient numbers of staff to meet people's needs.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance <b>Regulation 17 (1)(2)((b)(c)(f)</b> People were not supported through the operation of effective systems and processes to assess, monitor and mitigate risks to their health and welfare. Accurate and complete records had not always been maintained to inform decisions taken in relation to the care people received. Information was not always sufficient to evaluate and make improvements to people's quality of care.