Mr & Mrs C B Ellis

Rookwood Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Rookwood Residential Care Home (known as 'Rookwood' by the people who live there) on 18 December 2017. At the last inspection on 27 August and 1 September 2015 the service was rated Good.

Rookwood provides accommodation for up to 17 people with mental health needs who require support with personal care. At the time of our inspection there were 16 people living in the home. Accommodation is provided over three floors and comprises of three lounge areas, a dining room and kitchen. The home has a sheltered smoking area, which is located in the garden. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post who was responsible for the day-to-day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and registered manager had not ensured the service was being run in a manner that promoted a caring and respectful culture. During the inspection we found seven people's care plans had a section called 'consequences'. We found the provider adopted this method of issuing consequences when people had not followed the rules within the home. This meant people would have their personal items removed such as their televisions, kettle, radio, money and cigarettes for a short period of time. The home was not equipped to manage behaviours that challenge others in a safe and person centred way and issued the consequences as a punishment. Due to the seriousness of this un-safe and undignified practice the Care Quality Commission (CQC) raised a safeguarding concern with Bury local authority safeguarding team.

During this inspection, we found issues affecting the safety of the environment. The provider did not have a risk assessment in relation to legionella. The provider confirmed they had completed routine sampling of the water systems in 2015; however there was no scheme of delegation as to who was responsible to ensure the water systems were safe at the home. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults. The provider had also failed to undertake a risk assessment in respect of the hot radiator within the home, to establish if the radiators required covering. Since the inspection the provider have produced evidence a legionella risk assessment is now in place.

Staff had received training, supervision, and appraisals to support them in their roles. However, we found staff had not received key training in learning disabilities awareness and behaviours that challenge others. Furthermore, we found mental health awareness training had not been completed since 2014 by the majority of the staff, with four staff still waiting to complete this key training subject.

Each person receiving a service had a care plan in place. The risks identified through the provision of care had been assessed. However, we found one person's care plan and risk assessments had not been reassessed when we were informed the person has had a history of choking incidents. As a result we raised a safeguarding referral to the local authority.

Care plans did not include people's goals and aspirations. We found no evidence documented of people's setting goals and being supported to achieve them.

Activities on offer to people were limited. We received a negative response from people in relation to activities at the home. There was no plan of activities available. This meant people were not always protected from social isolation.

People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. We found the provider had failed to make one application under the Deprivation of Liberty Safeguards (DoLS).

Overall people spoken with were positive and complimentary about the service they received at the home. People told us that they felt safe and were cared for. People received their medicines in a way that protected them from harm.

People had access to advocacy services if they needed them. The registered manager told us that the home would provide end of life care when needed.

There was a lack of governance at the home and effective systems to seek feedback about people's experience were not managed well. There was a lack of support and coaching for staff and this was reflected in the care they provided. Auditing systems were not robust enough to ensure that the service was compliant with the Health and Social Care Act 2008 and as a result these had not identified the concerns that we found during our inspection.

You can see what action we told the provider to take at the back of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
You can see what action we have told the provider to take at the back of the report. We are currently considering our options in relation to enforcement in relation to some breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people were not always assessed and reviewed to keep people safe.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

There were sufficient staff to meet people's daily needs. However staff did not have time to also arrange regular activities for people to be involved with.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were required to ensure staff had adequate training.

Improvements were required to ensure that Deprivation of Liberty Safeguards (DoLS) applications were monitored and fully understood.

Improvements were required to ensure that people received consistent support with their nutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect, due to the use of consequences when rules within the home had not been followed.

People told us staff were kind and caring.

People and staff developed positive relationships together and people were comfortable spending time with the staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were required to ensure people had accurate and complete care plans in place.

Improvements were required to support people with consistent care to achieve their goals.

We saw no activities taking place during the inspection. There was no structured plan in place to ensure people were socially stimulated.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of governance at the home. The provider did not have oversight of the service. There was not a positive culture within the service to ensure the delivery of person-centred care.

The provider did not always submit notifications to CQC when they were required to do so.

Accidents and incidents were not always recorded.

Rookwood Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 December 2017 and was unannounced. It was carried out by an inspector and 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.

Before the inspection we reviewed information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. We also reviewed the Provider Information Return (PIR). The PIR provides key information about the service, what the service does well and the improvements the provider plan to make.

We contacted both the Bury and Rochdale local authorities commissioning teams prior to our inspection and no concerns were raised by them about the care and support people received from Rookwood.

During the inspection, we spoke with 11 people. We also spoke with four members of staff. This included the registered manager, two care workers and one housekeeper. We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, six care plans, meeting minutes and auditing systems.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe. Staff we spoke with demonstrated a good understanding of safeguarding and were able to describe signs of abuse and the procedures to report any concerns they might have about people's wellbeing. All staff told us they had never seen any safeguarding concerns in the home and would recommend the home to family and friends. However, we found safeguarding procedures were not always effectively operated.

During the inspection two people commented that the home would remove their personal items such as their televisions, radios, money and withhold their cigarettes if they did not follow the rules within the home. We followed this up and found in six people's care plans they had a section called 'consequences'. For example, in one person's care plan it stated if the person smoked inside the home they would have their television removed, their kettle removed from their bedroom and staff would remove their cigarettes for a short period of time. We found six of the seven consequences were put in place to deter people from smoking in the home. However, one person's consequences were put in place due to the provider feeling at times the person was acting inappropriately, such as telling lies. This person's consequences was to have their money withheld meaning they could not access the local community and removing the person's radio from their bedroom. We found this person was living with a mental health condition and as part of their condition they were known to display behaviours that would challenge others. The home was not equipped to manage these behaviours in a safe and person centred way and issued consequences as a punishment.

We discussed the consequences with two care workers who both confirmed the consequences were used as a punishment for when people misbehaved or broke the home rules. Comments received from staff included, "I hate having to take people's televisions away, but this is what we have been told to do by the manager" and "We don't remove items often, but I suppose this is the right way." In discussion with the registered manager they commented that the consequences were introduced years ago from advice they received to manage people's behaviours and felt at the time this was acceptable practice. Shortly after the inspection the registered manager removed the consequences from people's care plans.

Due to the seriousness of this un-safe and undignified practice the Care Quality Commission (CQC) raised a safeguarding concern with Bury local authority safeguarding team.

This meant people were not protected from abuse and improper treatment to ensure the safety and wellbeing of people living at the home. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments did not clearly identify risks to individuals. Where risks to people had been identified records did not always include actions staff should take to mitigate these risks and keep people safe.

For example during the inspection we observed one person being supported by a staff member with their meal and they began to excessively cough. The staff member on duty informed us the person was at risk of choking and there had been previous incidences when the person required staff intervention, such as

rubbing the person's back and encouraging them to not rush their food. We viewed this person's care plan and found no individual choking risk assessment or eating and drinking guidance to provide information on how staff needed to safely support this person during their meals. During the inspection the registered manager informed us that they had contacted the person's GP in November 2017 to arrange an appointment, however, the registered manager phoned the GP surgery while we were present and commented their previous telephone call in November 2017 had not been logged. Therefore, the person was not known to the GP that they were at risk of choking. The registered manager provided us with a choking risk assessment dated November 2017 that was due to go in the person's care plan, however we found this risk assessment did not record whether the person would be referred to the GP for further investigations and what action staff needed to take if the person started to choke. Furthermore, the previous choking incidences had not been recorded by the care workers who observed this; the registered manager confirmed they would be addressing this further with staff.

Due to the seriousness of this person being at risk of choking the Care Quality Commission (CQC) made a safeguarding referral to Bury local authority safeguarding team. Shortly after the inspection the registered manager contacted us to say the Speech and Language Therapist (SALT) had now completed an assessment on this person's eating and drinking and made some suggestions on how staff needed to support this person.

We noted in a second person's care plan it was recorded that they were at risk of choking and required their food to be finely chopped up. During the inspection we discussed this with two care workers who informed us this person was not at risk of choking and the information detailed within the person's care plan was not an accurate record of the person's needs. We discussed this further with the registered manager and they were not sure why this information had been recorded, but did say this person's care plan would be fully reviewed.

We found one person living at the home had a history of inappropriate behaviours that presented a risk of harm to other people. There was a limited section about this person's behaviours in their care plan, however this plan was not detailed enough to provide guidance for staff in relation to how to manage these behaviour to prevent the risk of harm. The care plan did not provide the staff with step by step guidance on supporting the person to enjoy their life whilst enabling staff to understand when they needed to intervene to prevent an episode of challenging behaviour escalating. We discussed this further with the registered manager, who confirmed this person's care plan would be fully reviewed.

The provider was failing to adequately identify, assess and manage risks to people's safety and wellbeing. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. In discussion with the registered manager we were advised they did not have a legionella risk assessment in place. Shortly after the inspection the registered manager provided evidence of legionella bacteria sampling test completed in October 2015, which evidenced the samples were negative of legionella bacteria. However, the provider had not considered the use of a risk assessment in relation to legionella to establish who was responsible and whether there are areas within the water system that need to be tested in respect of legionella. We were provided with evidence of monitoring of the water temperatures and regular flushing of the water systems. However, with no legionella risk assessment in place we could not be assured the provider was taking reasonable steps to help protect people from the risk of contracting Legionnaire's. Shortly after the inspection the provider produced evidence that a legionella risk assessment was now in place.

During the tour of the home we noted that the radiators were very hot but did not have covers to prevent people from burning themselves. Contact with surfaces above 43 °C can lead to serious injury. Prolonged contact often occurs because people have fallen and are unable to move, or are trapped by furniture. Incidents often occur in areas where there are low levels of supervision, for example in bedrooms, bathrooms and some communal areas. We spoke with the registered manager about this and were advised they did not feel this was a risk to people at the home as the majority of the people could manage their day to day needs independently. Since the inspection the registered manager has contacted us to say that radiator covers will soon be in place and awaiting to be fitted.

The Health and Safety Executive guidelines states the following 'Managing the risks from hot water and surfaces in health and social care', many radiators and associated pipework are likely to operate at temperatures which may present a burn risk. Where assessment identifies that vulnerable people may come into prolonged contact, such equipment should be designed or covered so that the maximum accessible surface temperature does not exceed 43 °C. We found the provider had not considered this area and a risk assessment of the premises had not been carried out to identify what controls were necessary and how the systems will be managed and maintained.

During the inspection we found the front door of the home had been left wide open with no staff in close proximity on two separate occasions. We found some of the people were free to leave the home when they chose to, but this was not the case for two people who were not free to leave the home due to their conditions stated in their Deprivation of Liberty Safeguards (DoLS). Furthermore, this presented as a risk of strangers entering the home. We discussed this area with the registered manager who confirmed they would consider installing an alarm on the door which will notify staff when it is open.

The provider had not taken reasonable steps to ensure the premises and equipment were safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected the systems in place for the storage and management of medicines. The service stored people's medicines in a lockable cabinet stored in the registered manager's office. The medicine's fridge temperature and the treatment room temperature had been recorded daily to ensure medicines were stored at the correct temperature to maintain their efficacy.

There were no controlled drugs being used by the home. We were also told that no-one was being given their medication covertly which means without their knowledge and consent. Where people were prescribed 'as required' (PRN) medicines there were sufficiently detailed protocols in place to guide staff as to when the medicine may be required.

During our inspection we observed there to be enough staff to attend to people's physical needs promptly and assist at meals times and there were not any long periods where communal areas were left unsupervised. We did not receive any negative comments about staffing levels from people who used the service and we did not see people having to wait long for the support they required.

We looked at the provider's recruitment procedures. Staff told us they had the required checks before they were able to start work at the home. We checked two recruitment files and found references and a Disclosure and Barring Services (DBS) check had been performed to ensure potential staff members were of good character and suitable to work with people who lived at the home.

We reviewed the records for health and safety checks, including emergency lighting and evacuation routes, and they were all in order. Each person had a personal emergency evacuation plan or PEEP, the fire alarm

was checked weekly and regular fire drills had taken place. This meant the staff knew how to support people in the event of a fire or other emergency so individuals could be evacuated from the building.

The provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire that forced the closure of the service, the breakdown of the laundry or lack of staff. This showed us that contingencies were in place to keep people safe and ensure the continuation of the service in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had applied appropriately for two people to have a DoLS authorisation, for example one person lived in a secure environment and was therefore not free to leave the service at any time. However, we found one person's care plan stated that they had been assessed by a consultant psychiatrist as lacking a mental capacity. We found there was no mental capacity assessment in this person's care plan and no application had been made to the local authority. In discussion with the registered manager they confirmed the person had not been assessed, but this was something that was due to be done in the forthcoming weeks. We found this person had been living at the home since 2014 and a mental capacity assessment should have been completed in a timely manner to ensure the home was acting in accordance with the MCA 2005.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We noted three people who lacked capacity to make decisions for their care and treatment had signed a number of sections within their care plan to agree they consented to the information that was recorded. However, as stated, these people were deemed by the provider as lacking the mental capacity; therefore we could not be certain these people fully understood what they were signing.

Although staff had received training on the MCA and DoLS, we found staff had a limited understanding of MCA and the DoLS application process. One staff member said, "DoLS is about safeguarding people."

The provider was failing to work within the requirements of the Mental Capacity Act (2005) and there was a risk that people were being deprived of their liberty without proper lawful authority. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When staff began working at the service they completed an induction. New staff shadowed experienced colleagues to get to know people, their preferences and routines. We looked at records of training and saw training had been provided in areas including moving and handling, safeguarding adults, moving and handling, infection control, fire safety, food hygiene, health and safety, first aid and MCA and DoLS. However,

we found that four out of the 11 staff members had not received training in mental health awareness. Furthermore, we found this training was last delivered to the other seven staff in 2014. The home supported eight people who have learning disabilities and we found no training in this area had been provisioned to ensure staff understand people's different types of disabilities. We noted one person at times displayed behaviours that challenged others; we found no training in managing behaviours that challenge available for staff. This meant staff were not adequately equipped to ensure they understood people's needs.

The gaps in training of staff would mean the provider could not be certain that staff were adequately supported and skilled to provide effective support to people living at the home. The issues in relation to the competence and training of staff were a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider ensured systems were in place for new staff to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Staff members we spoke with told us that they received on-going support, supervision and appraisals. The registered manager told us that staff received regular supervision. We viewed the records and could see that this was taking place at least two to three times a year.

People told us that they liked the food that was offered. Comments received from people included, "The food is good to be fair", "I am a vegetarian and they [care workers] respect this", "The food is great on Sundays, this is my favourite day because they do a Sunday roast" and "There is plenty of food available, but they need to freshen up the menu because it does get boring."

We looked at how people were protected from poor nutrition and supported with eating and drinking. Where people were at risk of poor nutrition, we found one person had not been referred to a dietician in a timely manner to assess if appropriate food supplements were prescribed and offered. As stated previously in this report we found the provider had not ensured one person's eating and drinking requirements were safely assessed and conflicting information for a second person.

There was a set menu in place but people told us if they did not like what was on the menu then they could have something else. Drinks were seen to be offered between meals. We observed the lunch time meal experience and noted sandwiches had been made by the staff.

We saw in people's care files that they had access to a wide range of healthcare professionals and facilities. People were supported to make healthcare appointments such as with their GP, the optician, podiatrists, hospital outpatients, dentists and their mental health team. Those requiring or requesting assistance to attend appointments were accompanied by the registered manager.

During our visit we reviewed the care records of six people. Records showed people had their needs assessed before they moved into the service. During this assessment people were checked for their mobility, eating and nutrition, personal and health needs, communication and what support they needed on a daily basis. This ensured the service was able to meet the needs of people they were planning to admit to the service.

Requires Improvement

Is the service caring?

Our findings

We asked the people using the service if they thought the support staff were caring. People told us, "The staff are well mannered and polite", "I like the staff" and "This home is superb I cannot find fault personally."

Although we observed positive caring interactions from staff to the people living at Rookwood, we were not assured staff had received the necessary training and skills competencies to provide people with compassionate care. As reported in the effective domain of this report we found a number of staff had not completed key training in areas such as mental health awareness, learning disabilities and behaviours that challenges others. This meant some members of the staff team were not fully equipped to provide people living at Rookwood with personalised care due to not receiving the necessary training.

We found the culture within the home of issuing consequences was not caring or person centred. The registered provider had not considered alternative least, restrictive options, of ensuring people were not been punished as a result of behaviours that challenged others. Comments received from people included, "I do get upset when they remove my things" and "The staff are fine, but sometimes I feel I am being told off for no reason."

We found that the atmosphere in the home was calm and relaxed. During the inspection we observed how well staff interacted with people who used the service. We heard that staff were kind and caring in the way that they approached people. We saw that staff had built relationships and had good rapport with people. The home was relatively small and staff told us this enabled them to form good relationships. As well as this a number of staff had worked at the home for many years which supported continuity and familiarity.

People said that people were able to choose their own lifestyle such as when to get up and when to go to bed, choosing their own clothes and being able to go out when they wanted. We saw evidence of this when a person went out shopping.

We found people did not have the opportunity to review the progress of their care, as no systems such as the use of keyworkers or link workers had been established at the home to ensure people had regular one-to-one sessions.

We found the last residents meeting was in September 2017. The registered manager commented that they communicated with people daily and always welcomed suggestions and comments about the home and the support people received. However, with the lack of people's involvement this did not provide assurances people were given the opportunity to make suggestions in respect of the home or their care needs.

We asked the care workers about the people at Rookwood. The staff members we spoke with could demonstrate how they made an effort to recognise people's diversity, including their gender, race, previous jobs, spiritual and religious beliefs, thoughts and opinions. It was clear to us from observing the support provided, all staff had developed caring yet professional relationships with each person as they knew people's life stories, interests and who was important to them in terms of friends and family.

Advocacy services were available for people if they wished to access them. Posters promoting the benefits of advocacy were displayed on the ground floor.

None of the people receiving personal care services at the time of our visit had particular needs or preferences arising from their religious or cultural background. The provider's assessment process would identify these needs if necessary. Equality and diversity training was included in the provider's basic training programme.

Requires Improvement

Is the service responsive?

Our findings

Care plans were basic and generic, although they were reviewed and evaluated on a monthly basis to check if any change was needed. This evaluation did not always highlight if people's circumstances had changed. This meant that the level of support required by people was not assessed and documented so that care staff would understand how to meet people's needs. We found people's care plans were all stored in two connected folders, which was not person centred and did not ensure people's confidential information was protected. The registered manager commented that the care plans would be removed from the folder if family members or professionals needed to view individual care plans.

The provider used a 'This is Me' document which captured people's life histories including past work and social life to enable staff to provide person centred care and respect people's preferences and interests. However, we found this information was stored in a separate folder and not connected to the care plan. This meant staff may not see this information in a timely manner to ensure they fully understood people's life histories. In discussion with the registered manager they confirmed they would be reviewing the format of how the care plans are presented to ensure they fully capture people's needs in a person centred way.

We viewed six care plans and found people did not have aspirational care plans which set out their goals and ambitions in terms of rehabilitation and recovery or what the next step was for their accommodation and personal independence. None of the care plans we saw included people's longer term plans or wishes; they were focused on meeting people's health needs in the here and now. One person we spoke with said, "I have been at Rookwood for a while now, I think I am ready to move on but I am not confident at managing my medication." We found the provider did not have systems in place that enabled people the opportunity to manage their own medicines.

We found no evidence in people's care files that people were being encouraged and supported to become independent with a view to moving on from the home eventually. We were informed by the registered manager that these discussions did happen, but had not always been recorded. Three people told us the home did not provide additional support to improve skills, such as managing their own medicines, accessing the community, finances or cooking skills. We did not see evidence of how the home assessed people's daily living skills to determine the people's level of ability to manage activities of daily living themselves, such as getting dressed, taking a shower or preparing their own meals.

The provider had not ensured there was a system in place to support people to recover, rehabilitate and become independent. The lack of action plans to meet people's identified needs was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy called 'Philosophy of Care of the Home', which stated, "This will be achieved through a programme of activities designed to encourage mental alertness, self-esteem, social interaction with other service users and will recognise the following core values of care which are fundamental to the Philosophy of the organisation." However, we found this was not the case at Rookwood, as the home did not have a clear structure of how they promoted this 'Philosophy of Care of the Home'.

People's social needs were not being met. During the inspection we did not observe any pre-arranged activities for people taking place. We observed people sitting in the three lounges throughout the day with no social stimulation being provided. A small number of the people living at Rookwood independently accessed the local community and attended college or undertook voluntary work; however the majority of people living at the home did not partake in these activities due to a lack of staffing resources. Comments received from people were negative about the activities at the home, "There are no activities here", "My family will pick me up I look forward to that, because I don't get out otherwise. The staff are too busy to take people out"; "I get really worked up and frustrated as there is nothing to do here. My only enjoyment is my cigarettes, and I am smoking more due to the boredom", "Activities, you must be joking" and "I leave the home often, but other people are bored because they cannot leave like I can."

We spoke to the registered manager who commented that they needed to review the activities on offer for people. Comments from staff on activities included: "We just don't have the time to do activities" and "I do feel sorry for the clients because they are all bored."

We observed people had little interaction and stimulation throughout the day and found no evidence to assure us people's social needs were met. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's social needs were not being met.

We saw there was an up to date complaints policy that contained details of organisations external to the provider that people could contact if they were not satisfied with the handling of their complaint. The provider had not received any formal complaints.

People's end of life care needs and future decisions were documented and contained within care plans to help ensure people's wishes and choices were respected.

Inadequate

Is the service well-led?

Our findings

The culture within the service needed to improve as we found the home did not treat people with dignity and respect. The registered manager implemented 'consequences' in to the home by removing people's personal items as a punishment for breaking the house rules, such as smoking within the premises.

Procedures to review the quality of the service were insufficient and required improvement. We found that the quality assurance systems in place were not robust and did not examine many aspects relating to the running of a care home.

The quality assurance systems failed to review important aspects of people's care. For example, there was a lack of regular auditing of people's care plans to ensure they were current and accurate. The auditing systems did not recognise that the care plans did not give sufficient guidance for care staff to provide consistent and appropriate care, or that they correlated with the care that people required. The quality assurance systems failed to ensure there were adequate systems to monitor the quality and safety of the service, and that the service was complying with the regulations. For example, there were no checks to ensure that that incidents and accidents were recorded when required and that prompt action was taken when learning had been identified.

Improvements were required to ensure that people and their relatives, staff and other people involved with the service were encouraged and supported to provide their feedback about the care that was received. The registered manager provided evidence of four surveys that were returned in October 2017, this information was positive however it was not clear who had been sent the surveys and we found no surveys had been sent to people's relatives, staff and other people involved with the service and therefore the opportunity for the provider to reflect on people's feedback was missed.

Staff did not show an understanding of the Mental Capacity Act 2005. People did not always consent to their care and treatment and we found the provider adopted the approach of removing people's personal items, which was a form of emotional abuse. The provider was not consistently following the principles of the MCA and was not ensuring people who lacked capacity to consent were provided with care that was least restrictive and in their best interests. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

The registered manager commented that the owner of the home visited three times a week. However, we found the owner did not complete any audits of the home. The registered manager said the owner was involved but did not record any of their visits. This meant we could not be assured the provider had a clear overview of the service.

The provider had a clear procedure for recording accidents and incidents. However, we found accidents or incidents relating to people had not always been documented by staff. Therefore, the registered manager was not in a position to investigate further to ensure actions were followed through to reduce the risk of further incidents occurring. We were informed by staff of two significant incidents of a person choking;

however we found no record of this in the provider's accident and incident record book. There was no evidence of any follow up having been completed.

Although audits had been undertaken in relation to the environment and people's care, they had not been particularly effective in resolving the concerns found during the inspection in relation to the risk assessments, care planning, environment, activities and identifying people's future aspirations.

The provider had not ensured the service had an effective quality monitoring system was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The provider had not met all of the requirements of their registration. We found the provider had not notified us of two Deprivation of liberty safeguards (DoLS) applications and their outcomes. Registered persons must notify us about any applications they make to deprive a person of their liberty under the Mental Capacity Act 2005 and about the outcome of those applications. They do so at the same time using one standard form as soon as the outcome of the application is known.

The failure to submit notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

All the staff we spoke with said they were really happy working at the service. Comments included, "[Registered managers name] does her best for the home, I cannot fault her" and "This is a great place to work, we are all very caring and do our best."

Staff meetings were predominantly taking place twice a year. They were held at different times to capture all staff, day and night. Topics discussed were food, cleaning duties, care plans, training and on call procedures.

It is a requirement that the provider display a copy of their last performance assessment at the premises from which the regulated activity is provided and on their website. A copy of the last inspection report and rating was displayed on a notice board in the main lounge of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured there was a system in place to support people to recover, rehabilitate and become independent. And We observed people had little interaction and stimulation throughout the day and found no evidence to assure us people's social needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was failing to work within the requirements of the Mental Capacity Act (2005) and there was a risk that people were being deprived of their liberty without proper lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was failing to adequately identify, assess and manage risks to people's safety and wellbeing. And The provider had not taken reasonable steps to ensure the premises and equipment were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment to ensure the safety and wellbeing of people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The gaps in training of staff would mean the provider could not be certain that staff were adequately supported and skilled to provide effective support to people living at the home.