Oldercare (Haslemere) Limited

St Magnus Hospital & Rosemary Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rosemary Park Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Rosemary Park accommodates and provides nursing care for up to 73 people in one adapted building. The building is set out in four living areas, each with their own lounge and dining rooms.

At the time of our unannounced inspection on 28 November 2018 there were 62 people living at the service, all of whom were living with dementia or a mental health condition. Some people had a history of failed placements in other services.

There was a registered manager in place. 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 registered manager assisted us with our inspection.

At the last inspection in August 2015 we rated this service as Good in each of the domains. We found at this inspection some aspects of the service had not sustained this rating and as such we have re-rated the service in Effective, Responsive and Well-Led to Requires Improvement.

Staff were not following the principles of the Mental Capacity Act 2005. People had restrictions on their liberty without the legal procedures being followed. For example, we found a lack of decision-specific capacity assessments in place. Some care plan documentation for people was not up to date and did not include specific information. Activities were organised for people to attend, however we heard that some people wished more was going on or wanted activities that were individualised for them. We have issued a recommendation to the registered provider in respect of both areas.

Risks to people had been identified and action taken to help keep people safe. Staff were knowledgeable in their responsibility around safeguarding people from abuse and where people had accidents or where there were incidents, steps were taken to prevent reoccurrence and lessons learned. People received the medicines they required.

People lived in a clean environment that provided equipment suitable for their needs and was checked for its safety. Staff could describe to us what they would do in the event of an emergency, such as a fire. Staff received regular supervision and were trained and competent in their role in general as they had access to an education department which provided mandatory and specialised training. Staff went through a robust recruitment process before commencing in the role.

People told us they enjoyed the food and we found that where people were at risk of malnutrition, or they

had specific dietary needs, these were responded to. People's needs were assessed prior to moving into the service and in the event they required additional input from other healthcare professionals, this was provided to them.

People lived in an environment that was kind, caring and respectful. Staff showed people individual attention and spoke fondly of them. People were known to staff and encouraged to maintain relationships with those who were important to them.

Relatives and professionals told us they felt the service was well managed. Arrangements were in place to quality check the service and people, relatives and staff had the opportunity to be involved in the service. Senior management had good management oversight and the service worked with external agencies to help improve people's care. The registered manager met their requirements of registration. There was a complaints policy in place and complaints were investigated and responded to.

During our inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made three recommendations to the registered provider. You can read what action we have asked the registered provider to take in the main body of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe

People received the medicines they required.

People were cared for by a sufficient number of staff.

Risks to people were identified and addressed, this included risks of abuse and where accidents and incidents occurred.

People lived in an environment that was clean and checked for its safety.

Staff went through a recruitment process prior to commencing at the service.

Is the service effective?

Requires Improvement

The service was not consistently Effective.

Staff were not following the principles of the Mental Capacity Act 2005 as decision-specific capacity assessments were not carried out for people.

Staff were trained and received support and supervision in their role.

People's needs were assessed prior to moving in to the service and the environment was adapted for their needs.

People's dietary needs were met and where they required input from healthcare professionals this was provided to them.

People had access to adaptations that suited their needs.

Is the service caring?

Good

The service was Caring.

People were shown respect by staff and individual staff demonstrated a caring approach to people.

People were cared for by staff who knew them well, recognised their individual way of communicating and showed them attention.

People could maintain relationships that were important to them and make decisions in what they wished to do.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

People's care plans varied in detail and we found some examples where information was not always current for people. This included information around people's end of life care.

Although people had access to activities, we found further work was needed to help ensure individual people had activities specific to their needs.

There was an appropriate complaints process in place and complaints were responded to.

Is the service well-led?

Requires Improvement

The service was not consistently Well-Led.

Although there was good management oversight and relatives and professionals felt the service was managed well, we found shortfalls in some aspects of the service. These were not always identified by the internal quality assurance processes.

Relatives, professionals and staff had the opportunity to be involved in the service and give their feedback and make suggestions.

The registered manager complied with the conditions of registration and worked with external agencies to help continually improve the service.

St Magnus Hospital & Rosemary Park Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 28 November 2018 and was unannounced. This was a comprehensive inspection carried out by four inspectors. One of these inspectors acted as our expert by experience on the day. An expert by experience has experience of caring for or knowing someone who has lived in this type of setting. There was also a nurse specialist assisting with the inspection. The nurse specialist is a registered general nurse as well as a registered mental health nurse.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern at our inspection.

We contacted 10 social care professionals for their views of the service before we visited. We received feedback from three which we have included in our report.

During the inspection we spoke with nine people who lived at the service and five relatives. We also spoke with 12 members of staff plus the registered manager and deputy manager. If people were unable to tell us

directly about their experience, we observed the care they received and the interactions they had with staff. We looked at 14 people's care records, including their assessments, care plans and risk assessments. We checked training records and how medicines were managed. We also looked at health and safety checks, quality monitoring checks and the results of the provider's latest satisfaction surveys.

Good

Is the service safe?

Our findings

People lived in a service where they were kept safe. This was because staff identified, assessed and acted on risks to people and recognised their responsibility in keeping people safe from abuse. One person told us, "Yes, I feel safe because of the attitude of staff." Another person said, "I am safe as an old boot. Why? Because I am happy here."

People received the medicines they required. Where people were using pain patches we found there was no written indication that a pain patch had not been removed. We spoke with a staff member about this who told us they would start to put in the daily notes evidence that the pain patch was still in place. We found robust auditing processes in place from ordering, checking, storing, dispensing and disposal. People's individual medicines records had a photograph (for identification) as well as information relating to any allergies they had. There was a list of staff authorised to administer medicines with initials and signatures and annual medicines management competency assessments were completed. Where people used topical medicines (medicines in cream format) there were body maps in place to show where the cream should be applied.

Risks known to people were recorded in their care plans and supported by guidance for staff. Where people used bed rails to reduce the risk of them falling from their bed, risk assessments had been carried out. One person was at risk of choking and guidance recorded, 'sit upright, ensure [name] does not put too much on their spoon. Use a small spoon'. When one person was encouraged up to dance to some music during the afternoon, the staff member supporting them said, "That's it, nice and slow and steady" to ensure they were safe dancing. Where people were at risk of pressure sores, appropriate equipment was provided for them and they were repositioned regularly. We read how one person's sore had healed due to staff's input and care.

Staff were trained in how to recognise abuse and knew what they should do if they suspected it and they had a good understanding of procedures. A relative told us, "I leave here knowing he's looked after. I know I don't have to worry about him as he is cared for physically and mentally." A staff member told us, "(I would consider abuse) if people were not being given enough hydration or proper personal care for a long time. There is also physical and verbal abuse. If it was serious I would go straight to management." Another member of staff told us, "You have to be very patient with people and know their routines. They (people) remember if you are good for them and respond." A relative told us, "I can trust all the staff to provide good and safe care."

The service learnt when things went wrong. A staff member told us, "We have a debriefing when we have incidents." We reviewed accidents and incidents in respect of people and read that information was recorded in detail to include the event, what action was taken and the outcome. A monthly analysis report was produced by the registered manager to review for trends or themes. In addition, there were monthly safeguarding meetings which looked at incidents of abuse and what learning could be taken from them. We read that one person had left the service unnoticed by staff. As such, changes had been made to the way people were observed when outside in the garden to prevent a similar occurrence.

People were cared for by a sufficient number of staff. A staff member told us, "Yes, most days there are enough staff." Another told us, "We have enough staff to keep people safe. We rarely have temporary staff." A relative said, "[Name] is always clean, they change her immediately she needs it." We observed people being cared for in a prompt manner throughout the day and where one person required one to one support from staff they received this. People and staff did not appear rushed and a staff member told us, "I like working here because there are enough of us (staff)." We saw staff smiling and coming across as relaxed in people's company. We also noted in the relatives' recent satisfaction survey they reported they felt staffing levels were good.

The staff that cared for people had undergone a thorough recruitment process. We did not check recruitment files during this inspection as we had no concerns around this process during our last inspection of the service. However, we spoke with staff about the recruitment process prior to starting at the service. A staff member told us, "I had to have a DBS check and provide references and everything before I started." A DBS check looks at whether the prospective staff member is suitable to work at this type of service.

People lived in an environment that was cleaned regularly and was well maintained. A relative told us, "Standard of cleanliness is very good." They told us that the standard of the laundry was exceptional for a care home. Housekeeping staff were seen cleaning throughout the day and we found communal areas, including bathrooms and toilets clean. Staff were seen to wear gloves and aprons and had holsters on their belts which contained hand gel. Two people had an infection during our inspection and staff took appropriate infection control actions to prevent the spread of this infection. Both people were being barrier nursed (stringent infection control procedures) and disinfecting gel was available throughout the unit where they lived. Other units, relatives and visitors were also informed as were we when we met with the registered manager at the start of our inspection. Regular infection control committee meetings were held and topics discussed included personal protective equipment (PPE) and clinical waste. A staff member told us, "We never run out of PPE."

People lived in an environment that was checked for its safety. Health and safety checks were carried out regularly. This included fire safety checks, lift maintenance, emergency lighting checks, electrical and water safety checks. A staff member was very knowledgeable in relation to emergency processes, such as in the event of a fire. They could describe what staff must do if the alarm sounded, what equipment was in place to assist people in evacuating the building and where the meeting points were. They told us, "We would tell the emergency services we have frail people living here so they would know that it would not be easy to evacuate everyone."

Requires Improvement

Is the service effective?

Our findings

People were not always being supported to make decisions in line with the Mental Capacity Act 2005 (MCA) as there was a lack of understanding of the MCA and how it should be applied. The 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments had not always been carried out where necessary. There was a lack of evidence of where people lacked the capacity to make a particular decision that staff had consulted all relevant people, such as relatives and healthcare professionals, to ensure the decision was made in the person's best interests. We read people had capacity assessment checklists in their care plans that were reviewed monthly. However, they were not decision-specific and instead recorded, 'general for all aspects of daily life' or 'ongoing care and treatment'. One person had a sensor mat in place to alert staff when they got out of bed. However, there was no evidence of a decision-specific capacity assessment relating to this or a best interests discussion and decision.

People were at risk of having their liberties restricted. We found there were practices within the service which included locked doors, key fobs for bedroom doors and many people on 15-minute observations throughout the day. In one unit, 16 of the 18 residents were on 15-minute observations which were recorded, one was on hourly observations and the other one to one. There was no evidence in care plans to indicate why this was required. We spoke with staff about this who told us it was due to people's past behaviours. We asked if there had been any incidents to support this level of supervision. Staff told us that there had been no incidents of similar behaviour for several months, but that they (staff) were keeping people safe. Whilst the level of observation was reviewed monthly by senior staff, people were continually kept on 15-minute observations despite there being no incidents which meant that people were having unnecessary restrictions placed on them. It was not easy to navigate the building and locked doors and staff escorted people everywhere and if people wished to go to their room in one unit, they had to ask staff for this to happen. None of these practices were supported with decision-specific assessments or best interests discussions. In addition, we observed two people in particular who walked around one unit constantly during the day. Rather than let them find their way or leave them to walk back and forth, staff constantly went up to them to move them or prompt them to move (back to where they had come from).

We did not read decision-capacity assessments in people's care plans to support the restrictions that were in place around the key fobs for bedroom doors. Other restrictive practices not supported by the principles of the Act included people who had wheelchair belts in place. We asked a senior staff member if there were any further capacity assessments in place for people, being stored elsewhere, and they told us, "No, we just do these ones" which were the generic assessments. We did however see evidence in some people's records

of capacity assessment, best interests decisions and guidance in place for covert medicines (medicines given without the person's knowledge).

The failure to follow the principles of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to equipment suitable for their needs. We observed several people in specialist chairs, all with pressure relieving cushions. There were walking aids and hoists used to transfer people. People's rooms were clearly marked with their own identifying picture or symbol. Corridors were wide enough to enable people in wheelchairs to move around. In one wing there was a sensory room which had items such as lights, music and visual objects to allow people to relax. People's needs had been assessed before they moved into the service. A relative told us, "She needs to be here. They are providing the care she needs."

Staff had access to the training and support they needed to carry out their roles. A relative told us, "Staff know what they are doing." Another relative said, "All staff are well trained, even laundry staff." A relative told us they went to the education department to speak to staff about what it's like to be a relative to give, "Their perspective." A staff member told us, "We have very few agency staff. Many staff do stay so we get continuity of care." They told us they put this down to the training and career progression available for staff, adding, "Good education department – very supportive managers." Training topics included first aid, food hygiene, fire safety and moving and handling.

In addition, there was specific training in subjects such as end of life and medical emergencies. A staff member told us, "We have training to respond to medical emergencies and we are also supported by the main hospital if required." The providers PIR stated, 'all staff have been trained in the psychological techniques that can be used in de-escalation. This was confirmed by staff. One staff member told us, "I am being supported by the manager. I am up to date with all my training and also done modules on mental health awareness, management and prevention of challenging behaviour and aggression." Another staff member told us, "We can choose options of what we want to learn. I'm doing the TVN (tissue viability) training at the moment."

Staff felt supported in their role as they told us they had regular supervisions and an annual appraisal. This gave them the opportunity to meet with their line manager on a one to one basis to discuss their role, any training needs, concerns or professional development. A staff member told us, "The induction was really good and helpful. It is how I found out everything about everyone." Another said, "The induction and training taught me what I need for the job." We heard from staff how they had been encouraged to progress and to take leadership or management training.

Staff told us the teams worked well together and it was clear from our observations that staff knew what they should be doing and when. There was good team work taking place and consistent communication between staff. Staff said, "Now we work well together" and another commented, "All the staff are nice and we help each other without having to ask. It's a very nice staff team."

We asked people about the quality of food. One person told us, "Food is okay." Another person said the food was, "Great." We observed a choice of two meals and of squash. The mealtime was unhurried and staff sat with people who required assistance with eating. However, we noted that whilst people were asked what they wanted, those who lacked capacity were given a meal chosen by staff. A staff member told us, "They (the meals) are going to people who are severely cognitively impaired." We talked to the registered manager about this at the end of our inspection, suggesting they consider ways to support people to make their own decisions in what they ate, for example, by showing pictures or plated up meals.

People's dietary requirements were recognised and where people were at risk staff took appropriate action. The service had an on-site speech and language therapist and we read that they had reviewed people in relation to potential swallowing difficulties and choking risks. The outcome was that several people were on fork mashable or pureed diets. A 'nutrition and swallowing' group had been established to discuss and review any new guidance, such as the change in fluid thickener guidance. One person was on a soft diet and needed staff support. The member of staff took their time, waiting until the person acknowledged they wanted another mouthful and sat and encouraged them. Other people had specific dietary needs, such as an intolerance to wheat and again, appropriate food was provided to them.

Where people were at risk of malnutrition staff took appropriate action. The providers PIR stated, 'weights monitored monthly – moved to weekly if sustained weight loss recorded'. We found this to be the case as we read that one person had lost a large amount of weight over a six-month period. As a result, they were now on weekly weights, their food was being fortified, their fluid intake was being monitored and the GP was reviewing them regularly. From the records we reviewed we found people, in general, maintained a consistent weight.

People were supported to stay healthy and to obtain treatment when needed. There was evidence of professional input from the occupational therapist, domiciliary dentist and GP. One person was diabetic and we read that they had regular blood checks and an annual diabetic review eye check as well as regular foot care. A professional had written during a visit to the service, 'staff cooperate with our advice in order to ensure changes are carried out. They show empathy'. A relative said their family member had been helped by the speech and language therapy team with breathing and feeding difficulties. They said, "She has had several hospital appointments and they always get help very quickly." A professional told us, "I can say that when visiting the establishment in the past the team have all spoken very highly of the service and beneficial services … which means that patients in the nursing home element have more ready access to clinicians as and when required".

Good

Is the service caring?

Our findings

People were happy with living at Rosemary Park. One person told us, "Lovely place and the staff are beautiful." Another person said, "The staff are very good, they keep me well."

Relatives and professionals reiterated what people had told us. One relative said, "They (staff) talk to him and tell him what is happening; whatever they are going to do." They added, "I have never had to pull the staff up about anything, they are so caring. I would recommend the care here." A professional fed back to us, 'The member staff was observed to treat him with care, dignity and respect'.

There was a very caring atmosphere in the service and individual staff demonstrated a caring approach. Without exception we heard staff speaking kindly with people. A relative told us, "I can't fault staff in any way. Staff interaction is really good." We saw, in one wing, staff engaged with people and there was laughter and people joining in conversation around the table. Staff were supporting people with choices and asking people before helping them. There was a lot of reassurance for people with staff heard saying, "Well done" or for people to, "Take your time." A staff member said, "We care for people, talk to them and meet their daily needs." We saw a staff member take a person's face in their hands and congratulate them on their dancing, during a music session.

People were encouraged to maintain relationships close to them. A relative told us, "They treat her like their own family member." They added, "They (staff) encourage us to speak with them, but they also keep me informed of any changes with [name] or concerns." Another relative said, "There is a separate lounge for visitors and families here to meet with their relative." They told us they were made to feel welcome at any time.

During lunch time we observed staff taking time with people, helping them to eat their meals in a calm and unhurried way, checking people were okay and if they wished more or not. A person told us, "Nice people (staff) here, quite nice." Staff talked to people throughout lunch. We observed one person who initially did not want to eat lunch. The person was gently encouraged by staff to sit in the dining room area first and then encouraged to eat something after this.

People were given individual attention from staff. We observed a staff member speaking and interacting in turn with several people who were sitting in the sensory room. The staff member sat beside each person, at their level, holding their hand or talking quietly to them near to their face. People reacted positively to the staff member by smiling, kissing and holding the staff members face or their hand. One person was being supported to have a cup of tea by a staff member and we observed how they stroked the person's head to engage them before offering them the drink. Another person wished to regularly walk around and a staff member accompanied them, distracting them from situations that may have put them at risk (such as the hot tea pot) to enable them to move around as they wished. A relative told us, "Absolutely brilliant staff." A professional had written following a visit, '(staff) treat each patient as an individual and respect their wishes even when it is difficult due to the nature of the person's illness'.

Staff recognised people's individual ways of communicating. A staff member told us, "I know by his face and actions when he is agitated and that putting on music calms him down." This was in line with what was written in the person's care plan. We heard another staff member speak a few words in Spanish to one person as this was their first language. On another occasion we observed a person scowling at anyone who came near them. A staff member stopped and said to them, "Where's my smile [name]?" They repeated this a couple of times and managed to coax a brief smile out of the person. A relative said that their family member had started to lose their speech and staff had made some cards for them to look at to help them retain it. They said, "They went to the trouble of finding out that he had liked to do and made the cards to relate to these things." The art therapist talked to us about individuals and the way they expressed themselves through their art which was personal to each of them. They demonstrated they knew people well and adapted things to help them with the art work, telling us, "We give them non-direct support to build up their confidence and help with manual dexterity too." They added, "Even if people are confused and forget what they paint each time, we can use the art to communicate with them. It also stirs up memories for them."

People were shown respect, privacy and dignity. Staff knew people well. A staff member told us, "I would always call someone by their given name, not darling or love. I respond to people's needs and ensure that when I'm carrying out personal care it is done in private." A relative told us, "I see how staff treat people so well and there is respect." Staff could describe people's life histories, what they used to do workwise and things they enjoyed. Staff smiled when they spoke about people.

Requires Improvement

Is the service responsive?

Our findings

Although people had opportunities to participate in activities we found further work could be done on finding ways to meet people's individual needs. The providers PIR stated, 'staff to be aware and respectful of specific needs and where possible, enable access to events or community events that may facilitate preferences (in relation for people from the LGBT community)'. However, we found this not to be the case. One person was from the lesbian, gay, bisexual and transgender population. They told us, "I miss going out and miss meeting people of my own kind." They told us staff had not talked to them about this and there was no evidence to suggest that staff had investigated facilitating this person to meet like-minded people, either within our outside of the service.

One person told us, "It could be better – I'd like to go outside." Another person said, "I don't always join in. I am skilled in marquetry (woodwork) but (although staff know this) they don't have the veneers and equipment." A third person said, "I don't do much during the day." A relative told us, "There could be more one to one interactions and a bit more stimulation." We noted on the activities programme there were twice a week, 'therapeutic drives'. We asked a staff member what this meant and they told us, "It's just a drive." There were also twice daily 'walks' around the ground.

Activities took place including art and pet therapy, aromatherapy and music sessions. One person told us, "I like it (here). There always something going on. We do art and painting, all kinds of things Monday to Friday. People come in and sing. Weekends are quieter, but I don't mind that." There was a bus service three times a week into the local town for those who wished to go shopping. This had been introduced across the whole site and provided a transport service that was more accessible to people due to the location of the service. There was an art therapist on site and we read that people had requested more art sessions as they enjoyed them. We noted that there was the odd piece of artwork by people displayed on some wall lounges but there was little evidence of the art being used to personalise people's rooms, despite the therapist telling us that was what they did. However, we did hear that two people had won awards for their art work.

We saw some staff working with people in the lounge area to engage them in an activity, or they were just chatting. During the morning people made cards and there was a demonstration of a new piece of sensory equipment in the afternoon in one unit which people enjoyed. Although the lounge was full, not everyone had something to do or seemed engaged. During the afternoon there was a buzz in one of the unit lounge areas. We observed staff dancing with people, encouraging people up and to join in on the karaoke singing. People were clapping along to the music and clearly having a good time. Regular church services were held and although staff knew which people would normally attend they told us they still asked everyone. One staff member said, "We give people the choice, or ask their relative, as many don't believe." A relative told us, "They have always provided entertainment daily and at weekends."

However, we did read of examples of individualised activities for particular people in evidence provided to us following our inspection. This included taking someone with an interest in the second world war to a fort in Portsmouth, a person who liked model cars to a car museum and a gentleman who liked the garden to the Fishbourne Roman Palace where they could engage in specific activities.

People's care plans varied in respect of the information they contained. One person's was very specific in relation to their likes and dislikes and how they took their tea. It also held good background and personal information about the person. Each person had their malnutrition score recorded monthly, information on how they communicated, their night time routine, continence, nutrition needs and socialisation preferences. One person was recorded as requiring either one male staff or two female staff to support them during personal care to reduce the risk of them resisting the care. Staff confirmed this was the case. This same person had a serious allergy and there was guidance and information in place for staff in the event that the person was in that situation. Another person had behaviour that challenged, particularly towards staff during personal care. Their care plan recorded, 'do not discuss anything important with [name] when upset. Make conversation such as talk about their soft toys'. We saw this person had a soft toy with them during the day.

However, we found in the case of one person who had epilepsy there was a very basic care plan in place. It gave no guidance to staff on what to look out for, no description of the type of seizure this person may have or timings with regard to actions. Two people's care plans contained an overview dating back to 2009 which meant information may be out of date and another persons was dated 2013. This person was described as, 'remains physically and verbally agitated and aggressive most days due to her illness' however, this was not reflective of the person's current situation. Following our inspection, we were told by the provider's operation director that staff took epilepsy training as part of their induction. We were also told that people's overviews were admission summaries. It is important that people have personalised care plans specifically for them. This means that despite staff being trained, this person should have had an individualised care plan around their specific needs in relation to their epilepsy. In addition, although the overviews on people were written upon admission, these should be reviewed regularly to ensure the information contained in them remains up to date. The overviews were held near the front of people's care plans and as such could be read as the most current situation by a member of staff who did not know the person.

No one currently living at the service was receiving specific end of life care. We found care plans varied in relation to end of life information. One persons recorded they would like to leave their brain to science and wished to be buried in a military cemetery. However, others included information only as to whether they wished to be buried or cremated. This was confirmed by a member of staff who told us, "End of life care plans give basic information." One person had an advanced directive form that was completed but this did not reference what the end of life care should be for the person. We spoke with the registered manager about end of life care planning during our inspection. They told us, "We try where we can to speak to people and families, but sometimes they just don't want to talk about it." We discussed the need to continue with this work to help ensure that people's care plans recorded what input they wished to help ensure they had a comfortable, dignified and pain-free death. We did read however that some unused upstairs bedrooms were to be converted into a suite for relatives and visitors to stay if they had travelled long distances, but primarily for family to stay if their loved one was on end of life. We also heard from staff that the service involved the Macmillan nurses when people were at the end of their life.

We recommend the registered provider ensures people receive responsive, person-centred care which addresses their individual needs and is recorded in an up to date and accurate manner.

However, we did hear of examples of responsive care from staff. One staff member told us about one person who required one to one care both day and night. They said, "We have successfully weaned him off close observation at night. To deal with the risk initially he was on one to one both days and nights, but we then bought a special profiling bed for him and gradually reduced the observation from one to one, to 15-minutes and following then to 30-minutes when after two weeks the person had not had any falls (out of bed). Professionals felt staff were providing responsive care. One professional had written following a visit,

'always found staff very knowledgeable. Patients are generally happy, settled and calmer considering the care needs and behaviours for which they were admitted'. Another had written, 'has meant he had been able to be supported in the community. Nothing short of amazing!' As a result of staff undertaking recent training, the service had changed the drink thickener products. This had benefitted people as staff told us it was a better produce and did not have a taste like the previous product. A staff member told us, "People are drinking more because it is more pleasant."

We also read in the providers PIR some further examples of responsive care, either during their end of life or with specific, individualised needs. This included tracking down the daughter of one person who they had lost contact with, facilitating the end of life care for a person who had particular family traditions and a third person who had a likening for a certain type of food and supporting them to go to a restaurant each week which served it.

People had named nurses who co-ordinated the person's care and reviewed their needs. They also formed a therapeutic relation with people and communicated with other professionals and the person's relatives. A professional told us, 'I found staff who attended to me to be knowledgeable about the client and willing to ensure that I have the relevant information I required'.

There were appropriate procedures for managing complaints and concerns. One complaint had been received by the service since our last inspection. We reviewed the details of the complaint and read that a thorough investigation had taken place and a meeting held with the complainant to discuss the issue. A staff member told us, "(If someone wished to complain) they would tell us and I would transfer the information to the nurses or the managers." A relative told us that their queries were dealt with promptly.

We read of several compliments received by the service. These included, 'very happy with the care given', 'Mum always looks smart and well cared for', 'very friendly, competent and kind staff', 'staff are always helpful, caring towards my relative and keep me informed at all times about my relatives care or any changes that are relevant' and, 'I think all the staff are very good and very helpful. I have full confidence in them that they will do what is needed when is needed. I just wanted to say a very big thank you'.

Requires Improvement

Is the service well-led?

Our findings

Providers should be meeting the standards set out in the Health and Social Care Act 2014 Regulations and displaying the characteristics of good care. However, we identified shortfalls in the application of the principles of the MCA, record keeping and individualised responsive care and activities. As such we are unable to award a rating of Good in the Well Led domain.

Relatives gave us positive feedback about management. One relative told us, "It's got to be well managed when you see the staff. They are happy and this filters to the people they care for. It is also well staffed here. I know [registered manager] and [deputy manager] they are a good team and run things well." Another relative told us, "I can ask them anything; always get an answer."

People could voice their opinions during regular 'hotel services' group. This group was open to everyone to attend, although the registered manager told us there was limited interest from people. We read topics of conversation included catering, maintenance, laundry and housekeeping.

The providers PIR stated, 'annual questionnaires are distributed to staff and relatives, allowing anonymised replies'. We found this to be the case. We read that 27 responses had been received and that the feedback was very positive about the care provided to family members. However, we did hear that some relatives had fed back they would like to see more activities taking place. Following our inspection, the provider told us they had displayed timetables for activities in key areas frequented by visitors and added in more activities.

We also read a, 'you said', 'we did' poster which showed us that people had said they would like an Abba tribute band at the Christmas party, more drives out, more art sessions and a magic show. People's requests had been responded to and as such arrangements were in place to meet them. Other forms of communication to people and their relatives included, 'The Rosey Parker' magazine. This was a regular editorial which gave people information on celebrations held in previous months, news, up and coming activities, pictures of people involved in activities and general information about the service.

Relatives were involved in the service through a carers support group. A relative told us they could make suggestions through the relatives group. For example, they had asked for ramps to be installed in the garden to help people move around more freely. A relative felt this would be happening next year. We read that speakers presented at this meeting, covering topics specific to people's loved ones or information about latest practices and thinking in caring for people living with dementia or other mental health conditions. A carers group meeting was held on the day of our inspection and the art therapist spoke of the benefits of art psychotherapy.

Staff told us they felt supported by the registered manager. One staff member said, "[Registered manager] is very good. I ask her something and she will try and sort it out. She gives us good feedback." A second staff member said, "[Registered manager] is perfect as a manager – helps me out when I need it." A third member of staff told us, "I have been given promotion." A fourth said, "I enjoy working here, I am respected and I have grown so much by being here." This was encouraged by management." Staff were kind and seen to be

smiling; happy in their work. This was noticeable.

Staff had the opportunity to meet together to discuss aspects of the service and improvements that could be made. We read from one meeting that people had received two pillows each and a sofa had been replaced in one lounge area, both of these were instigated by staff feedback. New curtains and bed spreads, a low-rise bed for one person, recliner shower seats and bathrooms converted to wet rooms had resulted from the clinical services meetings. A 'boom box' was purchased during the summer to enable people to listen to music when in the garden. A staff member told us, "We have a good team here and we meet regularly as a team. We have strong bonds and a good understanding of each other." We read that staff across the whole site met together as part of a staff focus group, which demonstrated an inclusive approach within the service. Staff survey results from 2018 showed that staff reported positivity with working at the service.

Health and social care professionals also had the opportunity to give their feedback on the service. We noted that 15 professionals had completed a survey sheet since September this year. They rated the service on how professional they felt staff were, if they were made to feel welcome, staff's understanding of people's needs, the manager's response to issues, the quality of activities and the general environment. We read that everyone had scored the service 'good' or 'very good' in all areas. One professional had written, 'as always staff and managers are very responsive, open and transparent seeking advice/guidance/feedback and looking to improve care'.

Regular audits were carried out to review the quality of the service. We read infection control, care plans, medicines and infections audits took place. Care plan audits identified gaps in some records, however it was not always clear to see that deadlines had been set to rectify these shortfalls and as such action had been taken. We spoke with the registered manager about this during the inspection who recognised that this evidence was lacking. Following our inspection, the operations director told us they had put in place a deadline column on the audit form to monitor progress against the planned target date.

There were other practices in place to support the overall management oversight of the service. This included an organisational risk register held for the whole site involving staff and managers helping to identify, mitigate and monitor risk. Quarterly clinical staff meetings were held which had a rolling agenda looking at risk and quality monitoring. Senior and board level managers met every week to review performance indicators for the whole site and topics on the running agenda include safety, staffing and incidents.

The registered manager complied with their requirements of registration. They had completed the provider information return (PIR) as required. They also notified CQC of significant events and displayed their most recent inspection ratings within the service.

The registered manager had established links with external agencies. They told us they worked well with the local community mental health trust and had, "Tried for ages" to engage with the local Church of England church. As a result, a group attended regularly for social interaction and a church service. We observed this on the day of the inspection. Rosemary Park was also part of a voluntary cohort of nursing homes who are overseen by the local Clinical Commissioning Group to meet a set of criteria designed to make the service safer and more accountable to the local authority.

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 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured the principles of the Mental Capacity 2005 were being followed.