Mariarod Care Homes U.K. Ltd

Rosemount

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Rosemount is a residential care home providing personal care for up to 20 people. The service supports older people, some of whom may have memory problems. The service was previously inspected in February 2015 when we carried out an unannounced comprehensive inspection, and judged the overall rating of the service to be good.

In May 2016 we received concerns in relation to low staffing levels. As a result we undertook a focused inspection on 29 June 2016 to look into those concerns. Two social care inspectors arrived at the service at 3pm and left at 9pm.The inspectors looked at the staffing levels in the home to determine if the service was safe This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosemount on our website at www.cqc.org.uk.

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

People's health, safety and welfare were put at risk because there were not always sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times. During the day people had their care needs met in a timely way. However, after three pm the rota showed staffing levels reduced to two members of care staff, who were responsible for providing all care to the 15 people living at the home. Some people had dementia and could become agitated and some people needed two members of staff to support them with their personal care needs. These care staff also had responsibility for preparing, delivering and supporting one person to eat supper. They were also responsible for any other housekeeping jobs needed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

People's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times.

Rosemount

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 was 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 29 June 2016 was unannounced and was carried out by two Care Quality Commission (CQC) social care inspectors. At the time of our inspection 15 people were living at the home. People had a range of needs, with some people being more independent and others requiring more support with their mobility and care needs. Some people were living with dementia.

Some people living at the service were unable to comment directly on their care and experience of living at the home as they were living with dementia. We observed the care of people and staff practice in communal areas of the home and visited some people in their rooms.

Before the inspection we reviewed information we held about the service. This included previous contact about the home and notifications we had received. A notification is information about important events which the service is required to send us by law.

We met and spoke with three people who lived at the home as well as the registered manager and three care staff. We looked around the premises, spoke to people individually and spent time with people in the communal areas. We observed how staff interacted with people throughout the inspection.

Requires Improvement

Is the service safe?

Our findings

We spoke with people and asked them if they felt there was enough staff on duty to meet their needs. One person told us "there is no care; there is no staff to help me go out." Another person commented to us that "more staff would be a good idea."

We arrived at 3pm and there were three care staff on duty. The registered manager (also the provider) came back to the home when they learnt that we were undertaking an inspection. When we looked at the rota we saw that one member of staff was not scheduled to be working in the afternoon. This member of staff was scheduled to be on duty to accompany a person to a hospital appointment. However they remained on duty to support people until early evening and until the evening meal had been served. We spoke to the provider about the staffing levels and they told us they were satisfied that the home had sufficient staff on duty to meet people's needs. However, they did not use a specific tool to calculate people's level of dependency.

We looked at the rotas for the time period from 20 June 2016 to 3 July 2016. This rota showed that there were usually three members of staff on duty including a senior member of staff in the mornings with an additional member of staff between 7am and 9am. A house keeper was employed on weekdays whose duties included preparing breakfast and the lunchtime meal for people. The staffing levels from three pm until eight pm were then reduced to two staff. The care staff also had responsibility for preparing and serving the evening meal and all meals at weekends as part of their duties. The home had two night staff, one of whom was awake and the other who was available at the home to be called if required from 11pm until 8am the following day. The housekeeper did not work over the weekend. The provider told us no cleaning, except in an emergency, was done at weekends. However, staff did have to prepare meals over the weekend. The rotas did not reflect any increase in staffing levels to accommodate this.

There was not always enough staff on duty to meet the needs of people who currently lived at the home. People's care plans identified seven people who required two members of staff to assist them with their mobility. This meant when there were only two staff on duty, people had to wait for long periods before staff were available to assist them. This was because staff were supporting other people who required two staff, leaving no other staff available. One staff member was also responsible for administering medicines. This meant there would be only one staff member available to meet people's needs during that time. However, the provider told us that 'very few' people received medicines at 4pm and that the staff who came on duty at 8pm administered the medicines required at that time.

Following the inspection the provider wrote to tell us about people's care needs. They told us five people were self caring and went to bed at whatever time they chose. They said that four people went to bed between 9pm and midnight and that other people went to bed when they wished. However, while there were only two staff members on duty there would be times when people who needed help to go to bed would have to wait for long periods for help.

Staff told us they thought there were not enough staff on duty after 3pm. They said when there were only two staff on duty they were not always able to attend to people's needs in a timely way. For example, people

might have to wait to be helped to go to bed at a time they wanted to. Staff said that while they did manage to meet people's needs, they often had to rush people in order to do so. We saw that people had to wait for their needs to be met when there were three care staff and the registered manager working at the service. When there were only two care staff on duty people would have to wait even longer. Following the inspection the provider wrote to tell us they had discussed staffing levels with senior staff. The provider told us that the senior staff were happy that the current staffing levels were sufficient to meet people's needs. They told us that another person was due to be admitted and staffing levels would be increased due to this.

We spent time in the communal lounge observing the interaction between staff and people. We saw that people were unsupervised for long periods of time alone in the lounge when staff were attending to people in their rooms and supporting people to bed. There was little interaction between staff and people, but when staff did interact with people it was in a friendly manner. However, this was mostly task related, for example, helping with personal care, or giving out supper. Staff were rushed and some people had to wait for their needs to be met until staff had time.

Care records described how one person was prone to periods of confusion and agitation which might lead to them attempt to leave the home. The advice to staff was that they should at such times attempt to redirect the person and engage them in an alternative activity, or offer to accompany them for a walk as this helps to calm the person. This meant this person was at risk as at times there were no staff in the main communal areas to ensure their safety and follow the care plan.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk management at the home was not always managed to keep people safe. People's records did not always indicate that people's care needs were being met. People's files contained risk assessments in relation to their mental and physical health, such as pressure areas, risks relating to a person's nutritional intake and risk of falls. However, the risk management plans were not always communicated to staff. For example, we looked at the risk assessment for one person who had been assessed as being at high risk of developing pressure area damage (pressure sores). The person's care plan indicated they should be repositioned every two hours. We visited this person to check how well staff were managing their pressure area care. We found they were lying on a pressure relieving mattress and records from the previous day showed the person had been repositioned every two hours as advised. However, the repositioning chart on the day of our inspection indicated the person had not been repositioned for four hours. We spoke to the provider of the service about this and they told us that staff had probably forgotten to complete the chart. This meant the provider could not be assured staff were following instructions to minimise the risks of pressure damage. Following the inspection the provider wrote to tell us they had discussed the incident with the member of staff. The staff member had said that their pen had not been working and they had forgotten to go back and record the fact the person had been turned. The provider told us they had no concerns that the person was not being turned every two hours.

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 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent and skilled staff employed at all times to meet the needs of service users.