Rosehill Rest Home Ltd

Rosehill Rest Home

Inspection report

Rosehill Rest Home, Robins Hill
Raleigh Hill
Bideford
Devon
EX39 3PA

Date of inspection visit:
05 November 2018
07 November 2018
12 November 2018

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20 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 5, 7 and 12 November 2018. It was unannounced on the first day. This inspection was brought forward due to risk following concerns shared with us from the local authority safeguarding team. This was with regarding to poor practice and poor management at the service.

Rosehill Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premised and the care provided, and both were looked at during this inspection.

Rosehill Rest Home accommodates up to 17 people in one adapted building over three floors. There is a stairlift giving access to all three floors. There were 13 people living at the service when we carried out the inspection.

The provider was also the registered manager. A registered manager is a person who has registered with the CQC 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.

At the last focussed inspection in February 2017, there were two joint registered managers in post. Following that inspection, one of the joint registered managers applied to the CQC to voluntary deregister from this post. The provider remained the one registered manager in post.

At the time of this report, the local authority safeguarding team were continuing to investigate concerns raised. As a result of the concerns, the home was in 'whole home safeguarding' and there was a restriction on admissions to the home.

The service was not well led. There was no management structure in place and staff did not have clear lines of responsibility. The provider was being helped to run the service by the senior care worker. However, they did not have the skills or knowledge to undertake this role without further training.

There was a clear lack of governance in place, together with a lack of the necessary record keeping pertaining to the running of the service. There were record deficits in all areas and these records were either unavailable, could not be found or were not in place. The provider was aware of this and knew this was an area for improvement. Some of the records relating to the running of the business had had not been completed ort updated since 2016.

People did not receive individualised care suitable to their individual needs. Some of the care practices at the service were old fashioned and out of date. There was a lack of understanding of person centred care. Three people living at the home had not had a care plan in place since they came to live at the service. Other people did have a care plan but these were incomplete and the information held within them outdated.

Staff did not always treat and speak to people in a way which showed privacy, dignity and respect. Some practices at the service were old fashioned and contained 'unwritten rules' which impacted on people's daily lives and choices.

Risks to people's health, care and welfare were not identified and systems not put in place to reduce these risks. These included risks to people's nutrition, skin pressure damage, safe moving and handling, environment and falls.

People were nursed in specialised beds and some people had bed rails in place. This equipment was not regularly monitored and checked to make sure they were at the correct settings for the people's weights and were in good working order.

People had their weights monitored but these were not reviewed and appropriate referrals made where people had lost weight.

People did not receive their medicines in a consistently safe way. This meant we could not be sure people had received their right medicines, at the right dosage and at the right time.

Accidents and incidents were recorded and filed by staff. However, these reports were not analysed to identify any patterns or trends to reduce the risk of them happening again.

There was no activities programme in place and no record of any activities undertaken. There was a lack of meaningful interactions seen between staff and the people who lived at Rosehill, except for those related to daily living tasks.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do no support this practice. People were restricted in their choices due to a lack of appropriate assessment and care planning.

The service did not follow the principles of the Mental Capacity Act 2005 and people had not had a mental capacity assessment carried out. There was confusion as to which people living at the home had an application made to the local Deprivation of Liberty Safeguards team to deprive them of their liberty. None had not been completed in the last two years.

People received simple home cooked meals at set times, sometimes with more choice of food than other times. The lunchtime experience was not pleasurable and enjoyable for everyone. Some people were restricted to their bedrooms to eat their meals.

There was a lack of staffing which led to hurried care and support at times. There was only one waking night staff on duty when two people regularly required the help of two staff to support them. On other occasions, staff were unable to support people and take the time to sit with people, such as at mealtimes.

People were not involved in the running of the service and their views were not regularly sought on how it could be improved. There was a complaints procedure in place but some people did not feel able to voice concerns to the provider.

Staff were generally safely recruited, but they were not up to date in the training they required to do their jobs properly. They did not receive supervision and their hands on practice was not monitored. Staff understood the more obvious signs of abuse, but had not received refresher training to make them fully

aware of all the types of abuse.

Following the inspection, the provider contacted CQC on 22 November 2018. They informed us they would be appointing a new manager for the service who was due to start on 3 December 2018. They assured us of their intention to improve the service and practice to provide an improved home for people to live in. They confirmed they would be stepping down as the registered manager and the new manager would be applying to be registered with the CQC as soon as possible. The new manager also contacted CQC to confirm they were taking over as manager on the date given.

The local authority safeguarding team told us the provider was working with them to investigate the concerns made to them. The were in the process of reviewing people living at the service and found the provider and staff welcoming in their approach.

Full information about CQC's regulatory response to the more serious 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 questions 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, It 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.

We found seven breaches of the Health and Social Act 2008 (Regulated Activities) Regulations 2014 relating to staffing, person centred care, privacy and dignity, safe care and treatment, safeguarding, the need for consent and good governance. We found one breach of the Care Quality Commission (Registration) Regulations 2009 relating to the notification of deaths of people living at the service.

We made one recommendation relating to improving the lunchtime experience for people.

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 safe.

People's health, safety and welfare were put at risk because risks had not been identified.

People did not always receive personalised care due to the lack of staff on duty.

People's medicines were not managed safely.

People were protected by a safe recruitment process but gaps in employment history were not always discussed.

Accidents and incidents were recorded but not analysed to look for any trends of patterns to reduce a reoccurrence.

People were supported by staff who recognised the more obvious signs of abuse, but had not received up to date training in adult safeguarding.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who had not received the appropriate training to allow them to do their jobs properly.

The provider had not ensured staff had followed the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

Staff did not receive regular supervision and checks on their practice.

People received simple meals but were limited in choices of food available.

Staff sought advice from relevant professionals but this was not always recorded.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect in their practice.

People had limited choices over how they wished to spend their day and there was limited interaction from staff.

Is the service responsive?

Inadequate

The service was not responsive.

Some people did not have a care plan in place. For those people that did, the information was out of date and not always relevant.

People did not benefit from personalised care, there were set times and routines in place for people to live by.

People and relatives were not involved in decisions about the care delivered.

There was no activities programme. People's individual hobbies and interests were not considered.

People and relatives could access the complaints procedure but did not always find the provider open to them raising concerns.

Is the service well-led?

Inadequate

The service was not well led.

There were ineffective systems in place to monitor the quality of care provided and keep people safe.

A lack of environmental safety checks potentially put people's safety at risk.

There was no management structure in place and the provider had continued poor health.

The provider did not conduct audits to monitor people were receiving appropriate care.

There was a significant deficit in records relating to the running of the home in all areas.

Rosehill Rest Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 5, 7 and 12 November 2018. It was unannounced on the first visit and announced on the second and third visits.

This inspection was brought forward due to risk following concerns shared with us from the local authority safeguarding team regarding poor practice at the service. These concerns were kept anonymous at the request of the people and their relatives raising the concerns.

The inspection team consisted of two adult social care inspectors and an Expert by Experience on the first visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two adult social care inspectors undertook the second and third visits.

Prior to the inspection, we reviewed the information we held about the service. This included last inspection reports, safeguarding alerts and statutory notifications. A notification is information about important events which the service is required to send us by law.

The provider did not meet the minimum requirement to complete the Provider Information Return (PIR). 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. We also reviewed other information we held about the service. We took this into account when we made the judgements in this report.

We spoke and spent time with all 13 people receiving a service and spoke with 3 relatives. We spoke to the providers, senior care worker and five members of staff including care staff, kitchen staff, the cook, housekeeper and agency care staff.

We reviewed information about people's care and how the service was managed. We requested to see the following records: three people's care files and medicine records; two staff files which included recruitment records of the last staff to be appointed; staff rotas; staff induction, training and supervision records; quality monitoring systems such as audits, spot checks and competency checks; complaints and compliments; incident and accident reporting; minutes of meetings.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection in July 2016, safe was rated as good. At this inspection this rating had deteriorated to inadequate.

People were at risk of receiving inappropriate and unsafe care. This was because:

- Some people at the service were discriminated against.
- Risks to people's physical safety, along with risks to their health, were poorly managed.
- There were insufficient numbers of staff available to deliver individually led care.
- Medicines were poorly managed.
- Infection control procedures were not followed.
- Suitable plans were not in place if the building need to be evacuated in an emergency.
- Accident and incidents were not safely managed.
- People were not always moved safely and in line with the required legislation.
- Bedrails and air mattresses used to keep people safe were not regularly checked

There were 'unwritten rules' in the home which meant people were subject to institutional and discriminatory abuse, which infringed on their human rights. For example, when people were invited to go to the dining room for their lunch, a care worker told us three people were told to "go to their rooms." Another care worker said, "I don't understand why some people have their meals in their room … staff have told one person that she is not to come out of her room after lunch." Three people told us, "When it's dinner time or tea time I am told to have it in my bedroom… I was quite upset, I don't think it's right", "I have tea and coffee in the lounge but have my lunch in my room … staff won't let me back in the dining room" and "I have my lunch in my room, I don't know why." On the days of inspection, these three people ate in the dining room. It was obvious from their comments and confusion, this was not a regular occurrence. They were not used to sitting with each other.

People were not 'allowed' to eat their lunch in the lounge area. One person who was feeling unwell, said they did not want to go to the dining room for their lunch and wanted to stay in their comfy chair in the lounge. Four different members of staff tried to persuade this person to go to the dining room. Each of them told the person to go to the dining room and did not offer to serve their food where they were. Staff told us this was 'not allowed'. The person was eventually 'persuaded' to go to the dining room but only wanted a sandwich to eat and this was after the other people had eaten their lunch.

Staff had received safeguarding training in the past and were aware of the more obvious signs of abuse, such as that relating to physical signs. Staff were less clear about emotional, institutional, discriminatory and psychological abuse and how to recognise it. Training records showed three out of eight staff were up to date with this training. This meant people were at risk of being abused in a way which may be controlling or regimented, as staff were unaware of how to recognise it.

There had been two serious complaints raised to the local authority safeguarding team in the last two years.

One the most recent occasion, four relatives of people that had recently lived at Rosehill had raised concerns over how their family members had been treated. This included how people were spoken to and had unwanted restrictions placed upon them. For example, not being able to eat meals in the lounge area, having personal care at set times and going to bed early. This had become 'routine' in the service. These local authority safeguarding investigations were ongoing at the time of writing this report. The concerns raised related to the similar issues previously raised with the safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of avoidable harm due to poor practices at the service. There was a lack of up to date risk assessments in place for those people who required them. For example, those relating to risk of falls, skin integrity, nutrition, use of bedrails and mobility. One person had come to live at Rosehill due to the amount of falls they had received in their own home. There was no risk assessment in place to mitigate the risk of further falls or guidance to reduce the risk of further falls happening.

One person was at risk of skin pressure damage due to a lack of their mobility. There was no risk assessment in place to guide staff how to manage this risk accordingly. There was equipment in place to minimise some risk to this person, such as an air mattress. However, there was no guidance as to how this decision was taken. One care worker told us this person required special sheets to help them move in the bed, but these were not being used. The person was moved in the bed in an unsafe way by care staff.

Another person's air mattress was set on too high a setting, taking into consideration the person's most recent weight. This type of mattress should only be used for those people with existing skin damage, which this person did not have. Therefore, they were at increased risk due to this mattress being in place.

People had bedrails in place. There were no records in relation to whether bed rails or specialist beds had been risk assessed for safety for each person to minimise the risk of them getting trapped or falling.

Environmental risk assessments were not in place to guide staff about how to support people and ensure care and support was given in a safe way. For example, there were thermostatic mixing valves (TMV) in place to restrict the hot water temperature. However, these were not checked to make sure the water was within safe limits. There were no contingency plans in place should the stair lift break down, which would result in people being restricted to their bedrooms. A yearly water check for Legionnaires disease was carried out by an external organisation. However, no checks were made ion between these visits. There were several areas in the home where water was not routinely used, such as unused bedrooms, that needed Legionella risk prevention measures.

External risk assessments were not in place. There were several external risks due to the elevated position of the home which would pose a risk to people entering and exiting the service. For example, a steep incline to approach the home which was slippy with wet leaves. This posed a risk to people with mobility issues.

People's weights had been recorded regularly. However, there was no system in place for senior staff to monitor these and take any action required when someone had lost weight. There were three people who had gradually lost weight since the beginning of the year. When we asked the senior care worker what action had been taken to address the weight loss, they told us they not aware of it. This had not been reported to them by the care worker who had recorded the weights. Daily care notes did not always show details of how much food and drink people had taken during the day. Therefore, poor monitoring of people's dietary intake posed a risk to their wellbeing. No referrals for these people had been made to the GP or dietician, despite

one person having a high calorie food supplement.

Medicines were not safely managed and people were at risk of not receiving their right medicines at the right time. Medicines were kept secure in a designated trolley in the dining room but regular monitoring of the air temperature was not undertaken. Therefore, we could not be sure medicines were being kept within their correct temperature limits. There were a number of liquid medicines and eye drops. None of these bottles had an opening or expiry date on them, therefore it was unclear if they had passed their expiry date.

The medicine administration records (MAR) showed medicines were not always counted into stock when they arrived at the home. Therefore, staff were not always aware of what medicines were in stock at any one time. There were gaps in the MAR chart where people's medicines had not been recorded as given. One person did not have a MAR chart until the third day after they came to live at the service. It was unclear from the MAR chart whether or not the person had received or refused their medicines as there were no records in place during that time. The senior care worker was unable to confirm this and was unsure if they had received their medicines.

Within the medicine trolley was a tray with people's names on them. A care worker confirmed medicines were 'secondary dispensed'. This meant medicines were put in the pot by the first care worker and given to the person by a second care worker. This was inappropriate practice. We discussed this with the senior care worker and referred them to the relevant guidance and legislation.

Medicines were only dispensed by senior care workers. However, due to a recent period in short staffing, there was not always a person on duty trained to administer medicines either during the day or at night. This had resulted in staff telephoning the senior care worker at home when they were off duty to come in to Rosehill and give people their medicines and then go back home. One relative told us care staff had told them they were unable to give out medicines during the night and they were concerned their family member might need pain relief and not be able to have it. We discussed this with the senior care worker who said care staff would ring them up to come in if this situation arose.

People were prescribed medicines 'as and when' they needed them (referred to as PRN), such as for pain relief. When dispensing these medicines, it is important to note why they are being taken so further action can be taken if patterns are observed. This had not been done. Some of the PRN medicines were given routinely. However, the service had not asked the GP or pharmacy to review the medicines to make sure they did not react with other prescribed medicines regularly given.

Where changes in medicines or the dosage took place, these were not recorded appropriately. For example, the senior care worker told us of the changes in one person's medicines from a community nurse. However, there were no records to show why or on what date this had occurred. Daily care records were scanty and did not show detail about the conversation which took place.

Prescribed skin creams and lotions were not being recorded on a body map and it was unclear which part of the body and at what times these should be given. No audits of medicines had taken place since 2016.

All the above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not having their care and support needs met because there was not always enough staff on duty to support them. There were two care workers on duty on the morning shift, two care workers on duty on the afternoon shift and one waking care worker on duty at night. There were people living at the

service who required care and support with the aid of two staff at all times. For example, one person was cared for permanently in bed. They were at risk of unnecessary skin pressure damage and needed to have their position changed regularly. They required aids to support this. During the night there was only one person on duty so this would not be possible.

Another person who ate their meal in their bedroom required assistance and encouragement from a care worker to sit with them. However, the two care staff on duty were needed to give out meals to other people in the dining room which meant this person could not have assistance from staff on each occasion they ate their meal.

For those people living with dementia, there was a lack of meaningful interaction between them and staff. For example, one person sat in their room all day. With the exception of staff completing tasks, such as giving them personal care or serving their meals, staff did not spend meaningful periods of time with them. These people did not have the cognitive ability to call the alarm bell for staff, so were reliant on staff visiting them regularly to ensure they were safe and had their wellbeing needs met. The provider said they could not afford to employ extra staff to sit with people to encourage them to eat their meals, undertake wellbeing visits to people and support individual activities.

The service did not use a tool to work out the individual needs of each person and the numbers of staff required to support them. There were current vacancies at the service which were being covered by other permanent staff and by regular agency staff. We observed there was little time for staff to engage with people, except for a game of dominoes mid afternoon. The providers said they were "around all the time" to support care staff. However, it was unclear as to when they would be in the home as they were not included on the staff rota. On occasions, they were not in the building to support staff if needed, such as for taking people to hospital appointments. One relative said, "There was no one here running the place over the weekend."

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

Some safe recruitment practices were followed before new staff were employed to work with people. This included undertaking checks of identity, qualifications, and undertaking a Disclosure and Barring Service (DBS) criminal record check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, gaps in employment history were not routinely discussed and made it difficult to assess whether the care worker was suitable to work with vulnerable people. We discussed this with the senior care worker who confirmed they would add this information to their recruitment process.

People were not protected by staff following recognised infection control procedures. Whilst the home was extremely clean and fresh smelling, not all staff were seen to use personal protective equipment (PPE) appropriately. For example, staff wore the same aprons when delivering personal care to different people and did not always wear gloves at the right times. There was an old fashioned system of disposal of contaminated laundry which did not follow the principles of good infection control. For example, the disposal of clinical waste and dirty laundry from people's bedrooms in to the laundry area. We discussed this with the senior care worker and referred to the current legislation and guidance to follow.

Inadequate

Is the service effective?

Our findings

At the last comprehensive inspection in July 2016 and a subsequent focussed inspection in February 2017, effective was rated as requires improvement. At this inspection this rating had deteriorated to inadequate.

People did not receive care which was effective. This was because:

- Staff were not up to date with their training, supervisions and appraisals.
- The principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards were not followed.
- The lunchtime experience was not an enjoyable occasion for everyone.

People were supported by staff who were not up to date with their training. There was no comprehensive training matrix showing the training completed for each member of staff. 'Post it' notes on each staff's training record demonstrated poor compliance with the majority of the provider's mandatory training. For example, six out of eight staff were not up to date with safe moving and handling, nine out of ten staff had not completed health and safety training and five out of ten staff had not completed infection control training. We asked the senior care worker to forward a full percentage overview of all staff training to date. This had not been received at the time of writing the report.

Staff did not receive formalised induction training. We asked to look at the induction training for the last staff who had been appointed. There were no records available to evidence this training had taken place. The last induction training records available dated back to 2009. The senior care worker was unable to provide any evidence this training had been completed. They told us one of the two staff whose training records were not available were sure they had received an induction. There were no records to support this.

Staff did not receive regular supervision and appraisals in their work. The senior care worker and provider told us they knew they had not completed any staff supervisions, competency checks and appraisals for the last two years. Staff confirmed these had not taken place for over a year. The last supervision records available were dated 2016. Regular staff meetings were not held and the senior care worker could not remember when the last one was held. Staff told us meetings did not regularly take place. This meant there was a lack of opportunity for staff to discuss any issues, concerns or practice updates.

Staff were not provided with adequate up to date knowledge or the practical skills necessary to provide care based on current practice. For example, a number of people were living with dementia but not all staff had training in dementia awareness. From observations of staff, this was an area which would benefit both people and the staff supporting them.

All the above concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider told us new care workers who had no care qualifications would be supported to complete the

'Care Certificate' programme (introduced in April 2015 as national training in best practice). However, there was no one working at the service who had undertaken this training to date.

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 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.

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 (DoLS) were being met. We found the service was not working within the principles of the MCA.

People were supported by staff who had little understanding of the MCA and how it applied to their practice. When we asked staff what the MCA meant to them, they told us it was about gaining consent to have personal care undertaken. It was not clear whether staff had undertaken training on the MCA, this was not recorded and staff were unable to remember. When we asked the senior care worker what their understanding of the MCA was, they told us it was about giving people choices, such as what clothes they wanted to wear.

Mental capacity assessments had not been completed. In 2016 DoLS applications had been sent to the authorising authority. The senior care worker was unsure which people these related to. Since that date, new people had since come to live at Rosehill. When we asked how many people at the service lacked capacity to consent to their own care, we were told one person. It was obvious more people were unable to give consent due to their cognitive behaviour.

There were areas of the service which restricted people's movements, for example bedrails. The senior care worker was unsure of which people had DoLS submitted and which people needed a DoLS application completing. For example, one person had bed rails in use. There was no mental capacity assessment and no best interest meeting to confirm the use of bed rails was the least restrictive option to ensure safety.

This was a breach of Regulation 11 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

Care records did not show how people had been consulted about their care. For example, care plans had not been signed by people living at the home who had the capacity to be involved in discussions. Some people at the home were living with dementia; their relatives had not been asked to review the care plan and sign on their behalf when relatives had the legal power to do so.

People's comments varied on the quality and type of food received. Some people said they enjoyed their food whilst others did not. There were choices of food available on some, but not all, days. People were not included in decision making about what food to include in the menu options.

People told us they did not know in advance of the food they were going to eat, apart from Friday saying, "Friday is fish day." Comments included, "I don't know until I get it", "They will sometimes tell you what's for lunch" and "There is no menu, they are fond of putting onions in things, they do mine separately without

onions." One person told us they did not like the food they had been served. We mentioned this to the cook and asked what the alternative was. They said there was no choice and the person "would just have to leave it." Another person told a care worker they did not like the beetroot on their place. The care worker told them to leave it on the side of the plate. This person obviously found this distressing as they referred to it throughout the whole lunchtime meal and their dislike of beetroot on their plate.

The record of food followed showed basic and simple food was served. This included regular options of meals such as sausages, roasts, casseroles and stews. Desserts were simple, such as yoghourt or bananas in custard.

People ate lunch in two different sections of the dining room. People who could interact and socialise freely were in the area closest to the kitchen. In a second area of the dining room, out of view of the kitchen, other people sat who were not as able to engage in conversation with each other.

There was a lack of staff presence in the second area and staff were not available to assist and support people to eat. For example, one person was reluctant to eat their main course. Staff did not sit with them and encourage them to eat. They had two spoonsful of food and then ate no more. When their plate was taken away, they were asked if they wanted something else and were given a choice of a cup of instant soup or a sandwich. They chose a sandwich which was left in front of the person and later taken away also uneaten. They had a dessert they liked. However, after eating half their food, it was cleared away without allowing the person to finish it. Lunchtime appeared to be a hurried event.

The dining experience was not a pleasant and an inclusive experience for everyone. Some people showed behaviour which challenged others and, due to the lack of staff presence, resulted in raised voices and personal insults being given. There were no meaningful conversations between staff and people. One person became tearful and upset. Staff were unaware of this altercation as they were not present. One care worker told us, "We are told not to watch people while they are eating and keep out of the way." Another care worker told us everyone had to wait for the last person to finish their main course before desserts could be served. This meant some people could not finish their meal and were waiting long periods for other people.

People were not asked if they would like extra food or if they were enjoying their meal. Several people commented the ham served was difficult for them to cut but no help was offered. One person asked a care worker for more dessert. The care worker acknowledged this but the extra helping was not given.

One person ate their meals in their room and needed assistance from staff. The care worker spent time with this person and chatted to them throughout their meal which encouraged the person to eat. When we asked if this person was always assisted, they said sometimes the plates of food were left in their room for them to eat by themselves. The care worker said, "Other staff are always coming in and telling me to hurry up as I am taking too long to help (person) … Staff hurry people with their meals, it's not a nice approach".

People told us they had tea at 5.30pm and then an evening drink at 8pm. They told us there were no other food or snacks until breakfast the following day.

We recommend that the provider reviews the lunchtime experience to make it a pleasant experience for people to take part in.

People were able to tell us they were supported to have access to healthcare services and ongoing healthcare support. We observed people being taken for healthcare appointments. One GP said, "I feel

medical help is summoned when required". However, one relative whose family member had recently left Rosehill told us the service had been slow in responding to their request for a GP visit on one occasion. This was discussed with the provider who disagreed with the comment; no records were available to explain this comment. People had their feet treated by a visiting chiropodist.

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection in July 2016, caring was rated as good. At this inspection this rating had deteriorated to requires improvement.

The service was not always caring. This was because:

- People were not treated with dignity and respect.
- People's wellbeing was not always considered.

Care staff did not always treat people with dignity and respect when helping them with daily living tasks. For example, people had their personal care in two sections, divided by their breakfast. First, the person had their personal care started. This was referred to by care staff as people's "bottom halves". They were then served breakfast. Care staff then returned to finish off people's care referred to as "top halves." This meant people were half washed and dressed in clothing such as trousers and skirts with their nightie or pyjamas on at the same time until their personal care had been fully given.

People were not consulted about whether this was acceptable or not; one care worker said, "When I arrive at 8am some have had their bottom half washed by night staff or another person who starts work at 7am." They went on to say, "It's just what they do here and it's not right, I have told them … people do not get much of a choice, you go in and get them up. The senior carer does the top half and dresses them, they have no choice." The senior care worker confirmed the morning routine and said, "As soon as personal care is done, we take them for their breakfast."

We saw one person who was using the toilet adjacent to the communal lounge. Whilst they were in the toilet, another person went in to use the toilet but found it was engaged. They stood in front of them in the toilet and waited for them to finish. The person using the toilet was exposed, both to the person waiting and to others passing, throughout this personal process until they had rearranged their clothing and left the toilet. The toilet door was open throughout this process with no care staff noticing this inappropriate practice.

A further example of people not being treated with dignity was at lunchtimes. Some people had a clothes protector put on them. Staff did not ask people if they wanted to wear one of these protectors, they were put over their head and fastened at the sides without any conversation. One person had to wait to have a seat protector put on the dining room chair before they could sit down.

The service had the undignified practice of 'toilet times' for people who lived there. People in the home were persuaded to go to the toilet at set times. We observed this practice during inspection. One person said, "Before lunch they come into my room and say, 'Toilet before lunch' … I don't need reminding!"

People were not always spoken to appropriately, sometimes in a childlike manner. For example, during lunch one person leant forward in response to pain in their arms. They were told by a passing staff member

"Sit up please" without the staff member asking if the person was feeling unwell or if they needed help. The person quickly jumped and sat up straight.

On another occasion, one of the providers had returned from taking a person to an appointment. As they were walking through the lounge area, they were having some banter in conversation. However, the provider told the person in a loud voice whilst looking in the opposite direction at other people, "I don't like you" which the person did not hear. When we asked what this comment was in relation to, they said, "You just don't get it, that's how we talk to each other." We judged this comment to be disrespectful and inappropriate to the person.

This was a breach of Regulation 10 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

People personalised their rooms with sentimental and personal items, such as furniture and photographs. People's relatives and friends could visit and were made to feel welcome. One visitor said, "Staff were welcoming and helpful." Visitors and friends were charged for cups of tea and coffee if they wished to have refreshments with their family members. Some relatives felt this was unusual.

We had mixed comments on the caring attitude of the provider. Before the inspection, we had received negative information about how the service was managed. However, during the inspection four people told us how caring the provider was. One person said, "You are able to approach her, ask her advice. She is here every day, I would take my concerns to her, she would help me". A GP said, "Clients always appear well treated … staff seem caring and respectful."

Inadequate

Is the service responsive?

Our findings

At the last comprehensive inspection in July 2016, responsive was rated as good. At this inspection, this had, this was rated as good. At this inspection, the rating had deteriorated to requires improvement.

People's care was not always responsive. This was because:

- People's needs were not always assessed before they came to live at Rosehill.
- Care was not planned in a way which met people's choices, preferences and individual needs.
- People were not involved in decisions about their care.
- There was a lack of activities in place to suit people's individual hobbies and interests.
- The service did not comply with the Accessible Information Standard.
- Complaints were not always dealt with in an open and accepting manner.

People could not be sure their care needs would be fully met at Rosehill. Before people came to live at the service, the provider did not carry out a pre-admission assessment of their needs. The provider told us they decided in the next 24 hours after admission if the person's needs could be met fully. One person had recently come to live at Rosehill. The provider had asked them several times if they would like to move to a different home. They did this because the registered manager thought the person would have their needs met better living at an alternative service. The person said they did not want to move as they were comfortable at Rosehill and told us "…from the moment I got here, they made me feel welcome."

People who had been at the service prior to 2016 had care records in place. These had not been reviewed since then and not taken into account people's changing needs. Care plans contained some information which was still valid, but much of the information was out of date. For example, one care record contained the name and contact details of their next of kin. We were made aware the next of kin had passed away two years ago and the service did not have an alternative emergency contact telephone number for this person. When we asked the registered manager about the personal details in the records, they told us it was because they knew the neighbour had been friends with them. When we asked for a full record of each person's next of kin details, several of these were not known. This meant there were no contact numbers for people's next of kin in the event of an emergency or accident.

We looked at the care pathways of three people and their planned care needs. Two people had no care plan in place. This meant there was no guidance to ensure staff gave care in a planned, consistent and appropriate way. For example, one person had come to live at Rosehill with an acute illness condition. They had arrived at the service in October 2018. The 6pm daily record stated "(Person) keeps falling over … has been in hospital for 3 months stay and is at risk of admission again … was assisted with personal care to get washed and ready for bed … staff reported (person) has lots of bruises and dressings on." With the exception of the daily records, no other records had been put together. For example, no risk assessments relating to falls and no body maps showing injuries and no plan of personalised care.

This person was nursed in bed and there was no moving and handling equipment to help the person change

position in bed. The registered manager said their medication was "in a right mess" and it was three days before the person had had their medicine reviewed by the GP. From the medicine administration record, the person had not received the prescribed medicines which included those for pain relief. The person had a catheter fitted on 25 October 2018 and there were no guidelines in place to advice staff how to care for it. There were also no assessments relating to their skin damage and nutrition needs. When we asked the registered manager about the person's nutritional needs, they said, "They can have whatever they want."

At the time of the inspection, this person had been further assessed by the GP as at end of life. No further records were in place but a moving and handling slide sheet had been put in place. However, two care workers confirmed a slide sheet was not being used to moving and handling purposes. This person had no complaints about the staff's attitude and said, "Staff are great and ask me if I'm comfy." Their relative said, "Care has been excellent but it's the lack of communication I have a criticism about." The relative was referring to the fact that there was no one in charge of the service at the weekend and they requested a copy of the hospital discharge letter. Staff said they had no keys to access the office for the care records and did not know the documents were. It was four days before the relatives had the information they required.

Another person came to live at Rosehill in November 2018. They needed to be cared for at Rosehill following discharge from hospital. The GP has assessed them as "needs more support than she is currently receiving". This person had no care records in place, and no information relating to the monitoring of their falls. When we asked how the staff looked after this person, we were told "Nothing much, she looks after herself really."

Daily records varied in the amount of detail written about each person. Staff had made entries but they referred to the actions and tasks undertaken. For example, one daily record said "Assisted by (staff) to have personal care … refused to have breakfast … turned every two hours … refused to have any dinner … ate very little." However, no action was taken to encourage the person to eat or offer any alternatives or supplements. This person had a catheter in place. The amount of urine passed was not always recorded and staff were unaware of how much fluid the person had taken and passed out. The records made no mention of the catheter on the next day's daily records. This meant the service was not responding to people's changing needs.

All staff interaction with people was task orientated, such as giving drinks out and serving meals. With the exception of an agency care worker, there was little meaningful interaction between staff and people which showed kindness or compassion. The agency care worker displayed caring and concern to people, such as when someone was reluctant to eat their lunch and provided them with appropriate encouragement. They also played a dominos game with people in a gentle and inclusive manner.

People's wellbeing was not always addressed. They had limited choices in how they wished to spend their day. There were several routines at the home which people adhered to with set times for personal care, drinks and meals. For the people who were more independent told us they had choices about the times they liked to get up and go to bed. One person said, "I get up at 8.30am, my choice, and go to bed at 10:30, they let us stay up, as and when." The senior care worker told us people retired to their rooms between 7pm and 8pm. One person said, "They get me up early … I'm usually the first one in the lounge at about 9 o'clock. I go to bed when I'm called, usually about 7-7.30pm, it all depends on when the carers come for me." When we asked the senior care worker their understanding of person centred care, the commented "It's giving them a choice of clothes."

People received care and support based on old fashioned practice. It did not reflect current standards and demonstrate personalised care. This had a negative impact on people living at the service. For example, there was a "bath list." People told us they had a bath once a week on a designated day Monday to Friday.

People told us they were unable to have a bath on a weekend. One relative whose family member had recently left Rosehill told us "My (family member) was told to go to bed at a certain time."

For those people that were able, they followed their own interests and hobbies. For example, people went for trips out with their relatives. However, there was a lack of meaningful activities for other people living at the home. This meant people did not have the stimulation they required. For example, one person who was living with dementia stayed in their room most of the day. Staff did not visit them except for a task, such as giving them lunch or a cup of tea. This person spent all of their day sat in a chair in the bedroom listening to their radio which was on a channel not appropriate for their age. When we visited them during out inspection, the person spent most of their time bent over sleeping in their chair.

There was a dull, quiet atmosphere in the home, with little banter, laughing or chatting. For some people who did chat, this resulted in tension between people and potential altercations. When we asked what activities there were, we were told by one staff member "They (people) don't like activities". There were no activities log or planned programme in place. From the lounge area, we could hear three different radio channels which were set on different channels.

We looked at how the provider complied with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People did not have had information about their communication needs recorded in their care plans. Care records did not refer to any aids necessary to aid communication. Several people wore hearing aids and spectacles. People's glasses were smeared and dirty making it difficult for them to see. Two other people were unable to hear us as their hearing aids had run out of batteries and needed replacing.

All of these concerns were a breach of Regulation 9 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

There was a complaints policy and procedure in place which people could use to voice any concerns. There had been no recent complaints recorded. As reported earlier in the report, four people had recently raised concerns to the local authority safeguarding team. They did not find it easy to raise concerns to the provider and were worried about doing so. As a result, these concerns have remained anonymous and are currently being investigated by the local authority.

The service provided end of life care. One person living at Rosehill was now at the end of their life. They told us they were very comfortable and that they were well looked after. They said, "Staff are very, very great … they are lovely." The service had liaised with the local GP and community nursing team who were regularly visiting. When we asked the senior care worker how end of life care was organised and implemented, they said, "We always sit with them towards the end … we undertake last offices and always go and pick a fresh flower from the garden to put in their hands. We keep the family updated and the district nurses organise the 'just in case' boxes … I think we offer good end of life care." 'Just in case' boxes are boxed used by health care professionals. These are for a person at the end of their life when they might require specific medicines, such as for pain relief.

Inadequate

Is the service well-led?

Our findings

At the last comprehensive inspection in July 2016, well led was rated as good. At this inspection, this had deteriorated to inadequate.

The service was not well led because:

- There was no management oversight of the service.
- There was no management structure and clear lines of responsibility.
- There were no governance systems in place to monitor the quality of care delivered.
- Lessons had not been learned from previous safeguarding concerns.
- Practice was old fashioned and not in line with current practice.
- People's opinions were not regularly sought and they were not involved in making decisions about the service.
- There was a lack of personalised approach to people's care.
- There was poor record keeping of essential documents related to the running of the service and we could not be sure all information given was up to date.
- We identified breaches of regulation relating to key areas of practice.

The service is required to have a registered manager as a condition of registration with the Care Quality Commission (CQC).

At the comprehensive inspection in August 2015, the service was rated as requires improvement overall with breaches of regulation identified. The service had a registered manager in post at the time who was also the provider of the service. Following that inspection, a relative of the provider registered with CQC as the second joint registered manager. This was with a view to improving the leadership of the home and meeting the breaches of regulation.

At the next comprehensive inspection in August 2016, the service had improved and was rated good overall with the breaches of regulation met. The service had worked closely with the Devon County Council quality assurance improvement team to improve the deficits in practice and put systems in place to continually monitor the service.

In September 2017, CQC were notified the second registered manager had submitted an application to voluntarily deregister from their post as they no longer wished to work at the service. The service remained with the provider as also the one registered manager in place. The provider was supported by the senior care worker who was also related to them. The provider lived on the premises.

The provider did not meet the minimum requirement to complete 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. Therefore we had no information provided about the service at the time of inspection.

The statement of purpose for the service stated, "We aim to provide the best care for our residents that is possible … all staff are given induction training and ongoing training to enhance the quality of care … we treat our residents with respect and dignity and encourage care for residents without taking away their independence … we make every effort to improve the quality of their life … residents can choose how they wish to spend their leisure time and staff will organise therapy sessions which include gentle exercise to music, ball therapy, board games, and walks in the garden … in house entertainment is arranged as budget allows'. At this inspection we found the principles of this statement were not followed. This had a negative impact on people's safety, care, wellbeing and emotional needs.

The culture of the service was not person centred, open and inclusive. It did not always reflect positive outcomes for the people living there. There was no clear vision for staff to follow in terms of best practice. Some of the practices of the service were old fashioned and not person centred. Staff were very much task driven and there was an emphasis on cleanliness, tidiness and routine. Staff spoke of unwritten "rules" and practices at the service.

The leadership of the home did not reflect the importance of treating people as individuals in an equal way. People's individual needs were not always taken into account and they were discriminated against in some of the ways the service was run. For example, one person was upset they "were not allowed" to eat in the dining room with the other people at mealtimes because of their eating habits; they ate their meals alone in their bedroom. Another person who was living with dementia was restricted to their bedroom throughout the day. When we discussed it with the registered manager, they said, "They cannot eat with the other people it would not be fair, especially if they 'kick off'."

The provider had both managed and owned the home for approximately 30 years. They had not updated their practice with latest innovations and best practice care delivery. Their knowledge was based on previous experience of managing the home and had not always taken into practice modern methods of care, such as personalised care delivery. When we discussed the ethos of personalised care with the provider, they explained to us "People talk about personalised care … but it's not it's money care delivery as we don't get paid enough from the council to do this."

There was a lack of leadership and oversight of the service. The local authority safeguarding team, commissioning team and health and social care professionals had concerns about the overall management of the home. These related to the practice of the home and the manner they were treated by the provider. Although the provider took pride in the home which was kept in a very clean and good condition, they did not have up to date knowledge of modern day standards required.

Lessons had not been learnt from safeguarding issues raised by people and their relatives to the local authority safeguarding team in 2016. This related to concerns raised by families about the attitude, care and leadership of the home. Following that safeguarding meeting, the provider confirmed they would make changes to prevent a reoccurrence. Further concerns had been raised again recently which related to the same issues. This had escalated to four people leaving Rosehill and moving to alternative care services. As a result, the service was in 'whole home safeguarding'. This meant there was a hold on new admissions being referred to the service by the local authority as they could not be reassured of their ongoing safety.

Legal records relating to the running of the service were extremely poor or not in place. For example, care records did not always have up to date information on who the person's next of kin was and whether people had representatives who had Power of Attorney (POA). POA have legal rights to make care and welfare decisions on the person's behalf. The senior care worker was unsure as to who had a POA in place. In one care record, one friend was considered the next of kin by staff. However, this person had no legal right to

make these decisions which was the right of the person's relative.

On the first day of our inspection, the provider and senior care worker were both very clear that the records relating to the running of the service were not able to be found or had not been completed. They said the office had been disorganised since the joint registered manager had left the service and records had been like this since March 2017. They both told us records were out of date and specific records had not been completed, such as audits, care plan reviews, risk assessments and staff training/supervision records. They both told us the records needed attention.

The provider said, "The records were left in a mess and we can't find anything." The senior care worker said, "We have been trying to sort them out and we know they need doing and we are trying to do it." The lack of being able to find records necessary for the running of the service was confirmed on each visit. Much of the inspection time was spent trying to find missing or incomplete records by both the provider and senior care worker. For example, completed Deprivation of Liberty Safeguards (DoLS) applications for those people who were unable to consent to being restricted in some way. On our third day, the provider had found one completed DoLS application which was out of date.

Policies and procedures had been purchased from an outside organisation. However, these were generic and did not relate to the individual home. These did not always relate to the practice of the service, such as the staff recruitment procedure. These policies were not being followed and were not always accessible so were ineffective in the management of the service. The provider had purchased these policies but did not follow their procedures.

There was no effective governance system in place to ensure continuous improvement. The service did not consider good practice guidelines. For example, audits relating to people's medicines, accidents, care plans and falls were not undertaken. We found inconsistencies, gaps and a lack of record keeping throughout the inspection. The variability in the quality and consistency of record keeping meant we could not be confident people were receiving the individual care and support they required.

The provider did not involve people in decision making about the service or seek their opinions. People who used the service, their representatives and staff were not asked for their views about their care and treatment provided. The senior care worker did not think people's opinions had been sought through a survey since 2016; these records were unable to be found. Resident meetings did not take place and neither the provider nor the senior care worker could remember when the last one had taken place.; records were unable to be found.

Staff were unable to keep themselves updated and on best practice as there were no information technology services available at the service. There was one computer which was kept in an extremely small locked office. The provider only used the computer with the support of the senior care worker to assist them as they were unused to technology such as this. Staff did not have access to this office or care plans and policies and procedures when the provider or senior care worker were not at the service.

People were not always protected from the risk of insufficient staff being on duty. No dependency assessment was carried out as the basis for deciding sufficient staffing levels. The provider was on the staff rota but the times they were available were not recorded. This meant it was difficult to see how many staff were on duty at any time. However, there was evidence of staff shortages at times.

During the three days of inspection, we identified a number of breaches of regulation which had not previously been identified by the provider. These related to all the key areas of the report.

All of these concerns were a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

The provider is required by law to send CQC notifications about important events at the service. For example, deaths, serious injuries or safeguarding concerns. We had received six death notifications in the last 12 months. The provider and senior care worker were unable to confirm if we had been notified about all deaths as they were unable to remember. Records of deaths had not been kept, except for a recording in the cook's diary; these were incomplete and not meaningful.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Staff did tell us they felt supported at the service and one said, "(Provider) is a good boss, they understand my situation … all the residents love her." A GP said, "It (the service) seems well led and organised."