Cotswold Spa Retirement Hotels Limited

Rosemount Care Home

Inspection report

Sunningdale
West Monkseaton
Whitley bay
Tyne and Wear
NE25 9YF
Tel: 0191 251 0856
Website: fourseasons@fshc.co.uk

Date of inspection visit: 9,10,17 December 2015
Date of publication: 01/03/2016

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service in April and May 2015, at which five breaches of legal requirements were found. These related to person centred care, safeguarding, safe care and treatment, good governance and staffing. At the time of the inspection the home was under organisational safeguarding. Organisational safeguarding means that the local authority regularly monitored the practices and delivery of care at the home because of concerns about people's safety.

After the comprehensive inspection, the provider wrote to us to say what action they would take to meet legal requirements in relation to the breaches. We undertook a focused inspection on 9, 10 and 17 December 2015, which was unannounced, to check that they had followed their plan and to confirm that they now met legal requirements.

Summary of findings

You can read the report from our previous comprehensive inspection, by selecting the 'all reports' link for 'Rosemount Care Home' on our website at www.cqc.org.uk'

Rosemount Care Home is registered to provide accommodation for up to 60 people. At the time of our inspection there were 48 people using the service, some of whom were living with dementia.

There was a manager in post who had been at the home since May 2015. However, they had not formally registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We reminded the manager and the provider of the legal requirement for the service to have a registered manager in place as soon as possible.

Staff and people using the service told us they felt more staff were required to meet people's needs. Visiting professionals told us they often found it difficult to locate staff because they were so busy. Records showed that call bells were sometimes not being answered in a timely manner and occasionally rang for over 10 minutes. People said staff did not always have time to talk with them and they sometimes found it difficult to be supported with baths and showers. Staff said that if two staff were supporting a person, this could leave just one care worker available to support other people in their particular area of the home.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to 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).

The manager had submitted DoLS applications to the local authority for authorisation in line with legal requirements. Records showed that whilst consent was sought from people and documentation was completed to review certain aspects of care, the capacity of people to consent was considered, but not always clearly documented to demonstrate the Mental Capacity Act (2005) (MCA) was applied appropriately.

People and their relatives told us they felt safe at the home. Staff were aware of the need to protect people from abuse. They told us they had received training in relation to safeguarding adults and were able to describe the action they would take if they had any concerns. They told us they would report any concerns to the manager or the nurse in charge. The registered provider monitored and reviewed accident and incidents.

Suitable recruitment procedures and checks were in place to ensure staff had the right skills to support people at the home. We found medicines were appropriately managed, recorded and stored safely. Topical cream records were not always completed fully.

Staff said they felt they had the right skills and experience to look after people. They confirmed they had access to a range of training and training was updated where necessary. Staff told us, and records confirmed regular supervision took place and that they received annual appraisals.

People's comments about the food they were served were variable. Some people indicated the food was good whilst others felt there were areas that could be improved. We observed meal times and saw food was generally of a good standard, looked appetising and was hot. Kitchen staff demonstrated knowledge of people's individual dietary requirements and current guidance on nutrition. The social aspect of meal times was not always considered as staff did not always converse with, or direct people appropriately.

People and their relatives told us they were happy with the care provided. We observed staff treated people patiently and appropriately. They were able to demonstrate an understanding of people's particular

Summary of findings

needs. People's health and wellbeing was monitored, with ready access to general practitioners, dentists, opticians and other health professionals. We observed staff supported people in a caring and appropriate manner and with dignity and respect.

Care plans reflected people's individual needs and were reviewed regularly to reflect any changes required. We saw a range of activities were offered, including craft classes and other events, such as a seasonal carol service. Some people said they would like more trips out.

People told us they were aware of the complaints process and could raise issues if they had concerns. Formal complaints had been dealt with effectively and appropriately.

The manager had instigated checks on people's care and the environment of the home. She confirmed the regional manager also carried out regular audits. Records were not always up to date and accurately kept. We found gaps in records related to topical medicines and the delivery of personal care. Management audits had not identified issues related to the recording of effective best interest assessments and decision making. Information about people's history and backgrounds was not available in care records for staff to reference.

The majority of staff felt the manager was accessible and supportive. They also felt the deputy manager was helpful and caring. Staff and professionals told us the home was improving although communication systems needed to develop further. There were regular meetings with staff and relatives of people who used the service, to allow them to comment on the operation of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to good governance and staffing.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of the service were safe.

People, their relatives and staff told us there were not always enough staff available to provide the support they required. Records showed that call bells were not always answered in a timely manner. A number of people told us it was sometimes difficult to be supported with baths or showers.

People's relatives told us they felt their family members were safe living at the home. Staff had undertaken training in safeguarding and they had knowledge of safeguarding issues and recognising potential abuse.

Recruitment processes were robust and ensured appropriately skilled and experienced staff were employed. Risk assessments had been undertaken in relation to people's individual needs and the wider environment. Medicines were handled safely and kept securely, although topical medicine records were not always appropriate.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

There was evidence that applications had been made to the local authority safeguarding adults team to in relation to the Deprivation of Liberty Safeguards (DoLS). Corporate documentation regarding best interests decisions had been completed, but it was not always clear from records that the process followed, matched that required by the Mental Capacity Act (2005)

Staff told us, and records confirmed a range of training had been provided and staff received regular supervision and annual appraisals. People's wellbeing was effectively monitored. There were regular visits to the home by professionals such as community nurses and general practitioners.

We observed a range of food and drink was available at the home and people with specialist diets were supported. Interaction between staff and people at the home during meal times did not always encourage people to eat and drink.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and supported them in a patient and thoughtful manner. We observed people's dignity was maintained during care delivery and staff respected people's personal choices. People and their relatives confirmed that where possible, they had been involved in determining people's care plans.

Summary of findings

Staff were aware of the need to maintain confidentiality around all aspects of people's care.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's individual needs. They were reviewed and updated as people's needs changed.

There were activities for people to participate in. Entertainers and other events were also planned including a seasonal carol service. People said they would like more trips out. The manager said she planned to increase the available hours for activities at the home.

People were aware of how to raise complaints or concerns. Records of recent formal complaints demonstrated these had been dealt with appropriately.

Is the service well-led?

Requires improvement

Not all aspects of the service were well led.

Some records were not always effectively completed, including topical medicine application records and personal care records. Audits of records and documentation had not highlighted that consent documentation did not always meet the requirements of the MCA. Personal care records were stored safely.

The manager and regional manager had instigated a range of checks related to care delivery and the environment of the home. Most staff were positive about the support they received from the manager and deputy manager, and felt the home was improving.

There were regular meetings with staff groups and with people who used the service, or their relatives.

Rosemount Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 9, 10 and 17 December 2015 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor with experience of working in a nursing home environment and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

A Provider Information Return (PIR) was not requested prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Following the previous inspection the provider sent us an action plan detailing the action they would be taking to improve the service at the home. This inspection was carried out to check that the actions they had detailed had been put in place and improvements made. Prior to our inspection, we reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local clinical commissioning group. We used the information they provided to help plan the inspection.

Because of illness or confusion not everyone who used the service was able to speak with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 11 people who used the service to obtain their views on the care and support they received. We also spoke with eight relatives who were visiting the home on the days of our inspection. We talked with the acting manager, deputy manager, two nurses, one senior care worker, nine care workers, an activities co-ordinator, the cook and a member of the housekeeping team. We also spoke with a number of professionals who were visiting the home during the inspection including a representative of the local Clinical Commissioning Group, a community matron and a nurse practitioner.

We observed care and support being delivered in communal areas, including lounges and dining rooms, looked in the kitchen areas, the laundry, treatment rooms, bath/shower rooms and toilet areas. We checked people's individual accommodation. We reviewed a range of documents and records including; six care records for people who used the service, 13 medicine administration records; three staff records, duty rotas, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings of people who used the service or their relatives and a range of other quality audits and management records.

Requires improvement

Is the service safe?

Our findings

At the previous inspection in April 2015 we identified concerns about staffing numbers at the home and the length of time it took staff to respond the people's call bells.

At this inspection people and their relatives had mixed views on whether there were enough staff to support them with their care. Comments from people who felt there were not enough staff included, "Staff are very caring, but they are short of staff, I wait a long time for help"; "If I call for help to a carer passing, if they are not working on this side, they won't help, they tell me someone from this side will come" and "The staff never have time to talk when they come into my room". A relative told us, "There are not enough staff, and they are harassed." Some people and their relatives felt that staff did not always have time to deliver personal care, such as baths and showers. People also told us, "I can only have baths on certain days" and "I can only have a shower once a week." A relative said, "I am not sure when she last had a proper wash all over". However, other people and relatives said that staff were available. Their comments included, "We never wait long when we push the bell for help" and "They come quickly if I press the buzzer. They know I want something if I press the buzzer."

Staff told us that there were often not enough staff. They said that there should be eight care workers on duty for each day shift, but because some staff had left, and due to sickness, these staffing numbers were not always maintained. Comments from staff included, "The care workers are just rushing all over the place"; "A lot of the time the carers are dealing with paperwork. I think there should be more time for the residents"; "We struggle to answer buzzers on time. If there are two in a room that can leave only one care worker on the floor. If a person buzzes and requires assistance and that carer has to stay with them for five or ten minutes that leaves no one on the floor" and "There are not enough staff. People have very complex needs. There is no room for manoeuvre." One professional we spoke with told us, "Normally buzzers are ringing and ringing. Staff have mentioned concerns about staffing levels. Speak to people who are here and they tell you carers are trying to care, but they are incredibly stressed."

We spent time observing how staff responded to call bells and people's needs. We noted that care staff were constantly busy throughout the day. Where people were sat in one of the lounge areas of the home, whilst care staff checked on them when passing the door, it was rare for staff to sit in the areas with people. We spent time observing the lounge and found that periods of 20 minutes or more could pass without the lounge being fully observed. This meant there was a risk to people living at the home because regular checks on their safety were not maintained. We noted that on at least one occasion a call bell for a particular room rang for around 10 minutes before being answered. We checked the home's call bell records. We noted that whilst the majority of calls were answered in around five minutes there were times when bells went unanswered for more than 10 minutes and on two occasions monitoring information showed bells rang for 17 and 19 minutes respectively, before being answered. This meant that people's care needs were not always addressed in a timely manner.

One staff member told us they always made sure that people were clean and comfortable, but that it was sometimes difficult to ensure that people received regular baths and showers. We looked at a sample of personal care charts for people living at the home. Records did not always give a clear picture of the care provided and suggested baths and showers were not regularly provided.

Staff duty rotas for the month prior to the inspection indicated that on most days there were seven care workers on duty during the day, although for some shifts this dropped to six, due to sickness. In the week prior to our inspection some days staffing numbers had increased to eight care workers. On the first day of the inspection there were eight care workers on duty, although one staff member was on induction and not providing full support without supervision. On the final day of the inspection there were seven care workers on duty. We spoke with the manager about staffing. She told us that she had recently increased staffing number to four care workers on nights and eight care workers on days. However, she told us that recently had three care workers had submitted sickness notifications. This meant that staff were not always available to provide a responsive and appropriate level of personal care to people who lived at the home.

Requires improvement

Is the service safe?

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

Staff told us they had received training in relation to safeguarding adults. They were able to describe situations that may be regarded as potentially abusive and the action they would take if they were at all concerned. Care workers told us they would report matters to the nurse in charge or the manager and felt that any concerns would be taken seriously. The manager kept a file of any safeguarding matters. Referrals had been made to local safeguarding adults team and notifications sent to the CQC. The home had recently come out of 'organisational safeguarding'. 'Organisational safeguarding' is a process where the local authority monitors the activity of the home because there have been concerns raised regarding the delivery of care. We were aware that the home's management had co-operated fully with this process when it was in place and made improvements which satisfied the local authority safeguarding team. Information about the provider's whistleblowing policy was available throughout the home.

Risk assessments were in place in people's care plans and were relevant to identifiable issues appropriate to each individual. These included risk assessments linked to skin integrity, falls and choking. Risk assessments were also in place for the wider environment of the home. These included risks linked to the use of equipment in the laundry area, the home's kitchen and the control of substances hazardous to health (COSHH). Regular checks were carried out on safety systems within the home, including fire safety equipment, gas systems and water systems. Checks were also carried out on electrical items, lifting equipment such as hoists and mechanical baths and individual wheelchairs. This meant that proper check were undertaken to ensure risks were monitored and action taken to reduce their potential impact. Equipment had been checked to ensure it was safe to use.

Staff personal files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, interview notes, references being taken up and Disclosure and Barring Service (DBS) checks being made. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. Where staff were not originally born within the United Kingdom, checks had been made to ensure they had the right to work in this country. Registration of nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC). This verified the registered provider had appropriate recruitment and vetting processes in place. Staff who had recently moved to the service, or started working there, confirmed they had received an induction and an opportunity to shadow experienced staff before working alone. This mean people were supported by staff who had been subject to appropriate checks before commenced working at the home.

We observed nursing staff when dealing with people's medicines and saw people were given their medicines appropriately and safely. We examined the Medicine Administration Records (MARs) and found there were no gaps in the recording of medicines and any handwritten entries were double signed to say they had been checked as being correct. Medicines were stored correctly and safely. There were also systems in place for effective ordering and safe disposal of medicines. The deputy manager told us she had recently reviewed the medicine ordering systems and this had significantly reduced the number of "missing medicines" when the order returned from the pharmacy each month. A small number of people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. We found people had specific care plans for these types of medicines. A number of these plans were not dated, so it was not always possible to ensure they had been reviewed. We fed this back to the manager who said she would look to review the plans and ensure they were updated. Staff had received training on the safe handling of medicines and their competency was checked through direct observation.

At the previous inspection we had raised concerns about the cleanliness of the home and in particular areas such as showers, bathrooms and toilets. We had also noted that no infection control audits had been undertaken. At this inspection we noted improvements in the cleanliness of the home. Toilets and shower rooms were cleaner and areas where we had highlighted particular concerns had been redecorated. One bathroom had been completely refurbished and another was in progress during the inspection. The manager told us a third was planned for refurbishment during the new year. The manager had implemented monthly cleanliness and infection control

audits on the home. Domestic staff told us there were six domestic staff employed and that this was enough to ensure all parts of the home were regularly cleaned. We looked at people's ensuite facilities. We found a number of these areas were stacked with continence products. We also noted in a number of rooms that personal toiletries, including toothbrushes, were stored on a low shelf below the level of, and close to, the toilet. We spoke with the manager about this. On the second day of the inspection we saw continence products had been removed from the ensuite areas and toothbrushes placed on the side of the sink area and away from the toilet area. This reduced the risk of infection and cross contamination of personal care products.

Requires improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to 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).

At the previous inspection we found that the manager at the time had not assessed people in relation to the MCA or submitted applications in line with the DoLS guidelines. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager confirmed applications had been made to the local authority to ensure appropriate authorisation and safeguards were in place for those people who met the threshold for DoLS, in line with the MCA.

It was not clear from records whether full and appropriate best interest decisions were made, to ensure proper decisions were being taken about people's care where they could not consent to these themselves. We noted a number of people, who were being cared for in bed had bed rails in place to help prevent them falling. A corporately produced consent and risk assessment document had been completed. Whilst the form noted that there had been discussion with relatives and stated the reason why the use of bedrails was being considered, there was no evidence there had been a specific assessment of the person's capacity to make such a decision. A box asking if alternative equipment had been tried was not well completed. Therefore it could not always be determined that the use of bed rails was the least restrictive option and that people's rights had been upheld, as required by the MCA guidance.

We also noted one person was receiving medicines covertly. Covert medicines are given to a person disguised in their food or drink, because they may otherwise refuse to take them. Whilst there had been some discussion with the person's general practitioner, there was no evidence from records whether or not the best interests process had been followed to ensure the person's rights were protected. We spoke with the manager about these issues who said she would ensure the matters were reviewed and appropriately recorded to demonstrate proper processes had been followed.

Staff told us they had access to a range of training. Comments included, "We get regular access to training. It is on line mostly" and "Training is mostly ELearning, although not all. I did moving and handling about four weeks ago." The manager showed us a range of training records. We saw that a number of topic areas had been covered including; caring for residents with catheters, hand hygiene and a practical session on manual handling. Staff said they had regular supervision sessions and annual appraisals. Records showed that both group supervision sessions and individual sessions took place. We noted a number of individual supervision documents were direct copies, with just the staff name changed. We asked the manager about this. She said this had been done specifically as she wanted to ensure that key messages were covered and discussed.

Staff and visiting professionals told us communication had improved but there was still work to do at the home to improve further. Visiting professionals told us the home communicated well and made requests for advice, but these were often not co-ordinated. For example, each nurse on duty could ring separately to ask the GP to visit, rather than co-ordinate such requests in a single call. Staff and visiting professionals highlighted that care staff did not attend shift handover meetings. This meant they were not directly appraised at the start of a shift of any issues regarding the care of people living at the home. We attended a shift handover. The quality and detail of the information passed between the shifts was very good and would have proved useful to care staff when supporting people during the day. We fed back our observations to the manager. She said she would re view the handover process and was looking to improve communication in various ways, such as having a single diary for the whole home. Written handover information had improved, although staff said there was still room for further improvement, as this was the main source of information for staff when returning

Is the service effective?

from leave or days off. The deputy manager told us she had updated the handover sheets to include whether people had DNARs in place or emergency health care plans, so staff were immediately aware of this.

We saw people's wellbeing was monitored and maintained. People's care plans indicated they had access to general practitioners, opticians, dentists and other health professionals, when they required them. Reviews of care records demonstrated that referrals were made to the speech and language team (SALT) dietitian, tissue viability nurse and respiratory nurse if there were concerns about people's health and wellbeing. Staff also talked knowledgably about working with the palliative care team where people were approaching the end of their life. The home also benefited from weekly visits from the community matron and the nurse practitioner from the local GP surgery. Visiting professionals told us staff would raise issues with them on a regular basis, and seek advice, although they would like to see staff take more initiative and deal with matters for themselves in the first instance, based on their own knowledge and training. They said they have raised this with the home on previous occasions. The manager told us they had put in place additional actions for anyone presenting with weight loss, as well as seeking support from the community matron.

We spent time observing meal times at the home. There was a choice of two hot meals or salad served at lunch time. One person who did not like the meals served was offered a sandwich as an alternative. People were offered a choice of drinks with their meals. The food looked hot and appetising. Kitchen staff were aware of people who required specialist diets, such as diabetic or fortified diets, and were knowledgeable about the preparation of this type of food. Some people ate in one of the home's two dining rooms whilst others ate in their rooms. People who required assistance with dietary intake were supported by staff. However, there was limited interaction between staff and people whilst they were being supported, meaning the social aspect of mealtimes was not always considered. People's weights were monitored regularly. Where necessary referrals were made to the dietitian or the speech and language therapy service for advice and support.

Good

Is the service caring?

Our findings

People and their relatives told us they felt that staff cared for them or their family members well. Comments included, “We think she is getting excellent care here, they even look after us”; “The staff are very caring, they are very good” and “Some of the staff are very caring, but there have been a lot of new staff recently.” A visiting professional told us, “The carers are very caring” and “The care workers are trying really hard to care.”

We spent time observing and listening to how people and staff interacted. Staff always greeted people in a bright and friendly manner. They were generally patient with people, caring and understanding of their needs and their reactions. We heard staff take time to explain things to people and talk to people throughout the delivery of personal care. Staff also attempted to reassure anyone who was confused or disorientated. Non-care staff, such as domestics, also took time to speak with people as they went about their duties. We noted they chatted to people as they cleaned their rooms. One member of the domestic staff told us, “I love the residents. I like coming in and seeing them in the morning and talking to them when you clean their rooms. I just check they have had something to eat and drink.” Some staff said they would value more time to sit and speak with people to improve the care provided at the home. One staff member told us, “Staff have to be able to go and sit down and talk with them (residents).” Our observations of staff interaction with each other and residents/ relatives was that it was caring and meaningful.”

Some people and relatives told us they had been involved in planning their care, although other people were not immediately aware of what information was in their care plans. There was some evidence in people’s care plans that they had been asked about their personal preferences. For example, there was information in care plans about whether they preferred their room door open or closed when they were in the room. Preferences for male or female care staff to support people with personal care were also recorded.

Information about the service was displayed on various noticeboards. There was information about activities and events happening at the home, the results of the previous relatives’ satisfaction survey, notes from residents’/ relatives’ meetings and information about how to contact support groups or local authority teams. Staff told us that no one at the home had any particular cultural or religious preferences, at the current time. No one at the time of our inspection was accessing an advocacy service or being supported by an advocate.

Staff were aware of the need to maintain confidentiality. People’s care records were kept in locked or closed offices, except when being updated or referred to. Staff were also aware of the need not to discuss personal details outside the parameters of the work environment.

We observed staff treated people with dignity and respect and they called people by their preferred names. Staff we spoke with understood the importance of maintaining people’s dignity. They told us how they ensured people’s bedroom doors were closed and curtains drawn during personal care. We saw this was put into practice throughout our time at the home.

A small number of people were being supported with end of life care. The palliative care team had been consulted about the care and appropriate practices put into operation. Staff were working to ensure that all necessary equipment was available. Family members were able to visit people as and when they wished.

Good

Is the service responsive?

Our findings

People told us that staff tried to respond to their needs. Comments from people included, "If I ask anything they will go and do it. They are nice girls" and "They know how to look after me. I'm dead happy."

Care records were comprehensive and personalised with care centred on the individual and were not overly task led. They contained an assessment of needs, highlighting particular issues that people required support with. A number of people had recently moved into the home on an urgent basis. We noted that interim care plans were in place whilst fuller assessments were being undertaken. This meant care staff had information to follow to provider care whilts a moer comprehensive assessmenst as being undertaken.

Care records contained personal information such as, next of kin, GP and other significant people. Plans were in place for environment issues, nutrition/ diabetes concerns, communication requirements, personal hygiene, sleeping, pain management, social needs and medication. Additional plans were in place were people needed support with mobility or had behaviour that could be described as challenging. Care records generally contained good details of the issue and the approach to be followed.

We examined the care and care records of a number of people at the home in significant detail. People's identified needs and their care plans reflected the care being provided by staff. Where necessary additional advice and support was sought, such as for swallowing issues, dietary requirements or end of life care. We saw this advice had been incorporated into people's care plans. People being supported during the end of their lives had access to appropriate support and medication. This meant that care records reflected the care the staff were delivering to support them with specific conditions.

Care records were reviewed on a monthly basis and reviews were up to date. If people's need changed more frequently then care plans were updated sooner. Where appropriate, care plan agreement forms were in place and had been signed by the person or matters had been discussed with their representative. Some people had emergency health care plans (EHCP) in place, detailing the action staff should take if they became seriously ill and whether the person wished to be taken to hospital or remain at the home. Staff told us that all care plans were being reviewed to include an EHCP.

The home employed a full time activities organiser. The manager told us that she had some additional unfilled hours for an activities worker which she hoped to recruit to in the new year, adding further opportunities to develop a range of individualised activities. People we spoke with told us that activities were available for them to participate in. During our inspection we saw people engaged in making Christmas decorations and enjoying a film. A small group of people also put on a carol concert for friends and relatives. We spent time observing how the activities ran at the home. We saw that the activities co-ordinator had good interactions with people and appeared to be aware of their varying abilities and needs. One person told us that it would be helpful to have a minibus so that there could be more trips out. They told us, "They let me know when there are trips out, but we need our own bus, there is not enough room on the bus." A recent review by the local Healthwatch group had found a number of positive aspects about activities at the home.

A number of people were independent and went out to local shops or to visit a nearby public house for a drink and a meal. They also attended the local GP practice for appointments and a member of staff was made available to accompany them, if they wished.

People told us they were able to make choices. We noted people had a choice of meals and could also decide if they spent time in communal lounges or in their own rooms. Meals could also be taken in their rooms as well. People's preferences were recorded in their care records.

People told us they were aware of how to complain and would raise issues if they needed to. The service's complaints procedure was displayed at the entrance of the home and on notice boards. A record was maintained to monitor any complaints received and the outcome of each subsequent investigation. We saw a number of complaints had been dealt with and that the action taken was appropriate. Records indicated there had been an investigation, including examining records and speaking to staff and a note made of the action taken. A written explanation had been forwarded to the complainant detailing what changes had been introduced, such as care plans being updated and additional checks put in place.

Good

Is the service responsive?

The letters contained an apology. Two people told us that laundry did occasionally go missing, but they had not raised this as a formal complaint. This meant the provider was meeting their requirements under their duty of candour.

The home had received a number of cards and letters offering compliments about the care provided, although not all were dated. Two recent compliments stated, “Many thanks for making (name) birthday a happy one” and “Many thanks for the support you gave to (name). You always had her beautiful.”

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in place at the home. A manager was overseeing the running of the home and stated that she was in the process of making a formal application to register with the CQC. We spoke with the home's regional manager and reminded them that it was a requirement of the home's registration that there should be a registered manager in position at the home. The current manager was present during all three days of the inspection and the regional manager available for the first two days of the inspection.

The home was meeting other aspects of Health and Social Care legislation. For example, they were notifying the CQC of any safeguarding events, serious injuries, deaths or other signifcant events, as they are required to do.

People and their relatives told us they were aware there was a new manager at the home. Most people told us that the manager was approachable. However, one person said that they felt the new manager was not improving the service at the home.

At the last inspection we had found problems with how records were stored and maintained at the home. At this inspection, whilst the secure storage of records had improved and was appropriate, we found there were continuing problems with the maintenance of records.

People who were prescribed topical creams, because of skin damage or skin conditions, had individual records for care staff to record when the creams or lotions were applied. We found these records were poorly completed with significant gaps in recordings. Some creams, prescribed for specific purposes had been signed on the MAR sheets by nursing staff to say that care staff had applied the items. However, these topical cream charts did not show the creams had been applied. This meant we could not be sure that people had received the prescribed treatments in line with their care plans or medical advice. We spoke with the manager about this. She told us that the issue had been noted as a problem and discussed in staff meetings and during supervision. We saw documentation from supervision records indicating the matter had been raised with staff. The manager said she would remind nursing staff that they were responsible for ensuring records were completed by care staff.

Personal care records were also not always fully completed. These records detailed when people had been helped with personal care activities such as washing, shaving or oral care. They also recorded when people were supported to have baths and showers. We found gaps in these records on certain days suggesting that no personal care support had been given. Some people told us they found it difficult to request a bath or a shower because the staff were so busy. Records suggested that people had only received one shower or bath in a 17 day period, although body washes and bed baths were also noted. One person's care plan indicated they liked a weekly shower, although this was not recorded. The manager told us the person had not been well and had spent some time in bed, so had not been taking showers or baths. We checked the person's daily records and could find no indication that they had been offered or encouraged to have a bath or shower during this period. This meant we could not be sure that personal care was being delivered effectively because records were not always complete or up to date

Some people who were being nursed in bed had bedrails attached to their beds to help prevent them falling. Joint consent forms and risk assessments had been completed for the use of bedrails, where people did not have the capacity to consent themselves. Whilst staff had completed the provider's forms, they were often poorly completed and did not always comply with the requirements of the MCA. They did not fully indicate that the person's capacity to make specific decisions had been assessed, or that healthcare professionals or people's relatives had been consulted and that other, less restrictive options had been considered. Reviews of care records, as part of management oversight, had failed to identify that records failed to meet the legal requirements of the MCA.

We noted in people's care records there was no information about their personal background and history; their jobs when they were younger, interests, family and background. Similar information was not available in people's rooms. The manager told us that she had recently noted this. She told us this information was held by the activities co-ordinator only, meaning that care staff and nursing staff did not have ready access to people's history and background to help inform the delivery of personal care. The manager told us she would ensure that this information was made readily available.

Requires improvement

Is the service well-led?

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.

People we spoke with, and visiting professionals, told us that there had been improvements in the service delivered over the previous nine months. They said the present manager was working hard to bring about changes at the home and also felt the new deputy manager was a positive influence and had good clinical skills that could be utilised at the home. They told us that care records had improved, the incidence of skin integrity concerns had reduced and systems were slowly being implemented to ensure care was being delivered safely and effectively. They felt there was still some work to do in terms of continuing to develop effective communication and ensure that records were effectively maintained.

The manager had instigated a range of checks and audits assessing care delivery at the home including audits of medicine records, infection control audits and the general functioning of the service. The regional manager carried out monthly audits on a rolling programme based around the CQC's five domains. This included monitoring staff training, consent documentation and access to health services. Whilst the home had been in organisational safeguarding the provider's clinical facilitator had also been conducting reviews. These reviews had highlighted the continuing problems with care staff completing room documentation. The clinical facilitator also reviewed the competencies of nursing staff at the home.

With the exception of concerns over staffing levels, the majority of staff told us they were generally happy working at the home. They felt that the home was improving and the atmosphere was also developing, although all felt communication was an area that needed to be sustained. Staff were positive about the new manager and the influence that she was having on the home. Comments from staff included, "(Manager) is totally different. She has the interests of the residents at heart. She walks around the floor, which is good, and talks to families"; "You can go to her if you have a problem. I don't feel nervous of her. She is fair if you have a problem" and "I think she is good compared to others. I've seen worse and seen better. I think she is good. She is trying to improve and trying to do things." Staff were also supportive of the new deputy manager. Comments here included, "They are okay. They are a nurse, which is fine" and "(Name) the deputy is nice. They are good with the residents. They have a lot of time for the residents."

The manager had also restarted a range of meetings. When she initially took over she had developed regular daily flash meetings with all the heads of departments, to keep up to date with what was going on at the home. She told us that she still did have these types of meetings, but less regularly now. There were a range of other staff and residents'/ relatives' meetings documented as taking place. These allowed staff, people and realtives to raise questions about the running of the home, to feed back their views and to receive information about changes taking place.

Safety records, such as fire checks, gas safety and Lifting Operations Lifting Equipment Regulations (LOLER) checks on equipment were in place. Portable appliance testing (PAT) of small electrical equipment was up to date as were Legionella and water temperature checks.

The manager told us she recognised that there was still work to do at the home, but felt that improvements had been made and that staff were working hard. She said she was disappointed that the inspection had highlighted some continuing issues, but wanted to use the process positively to further move the service forward.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not in place to assess, monitor and improve the quality and safety of the service. Processes were not in place to ensure accurate, complete and contemporaneous records were maintained for each service user. Regulation 17(1)(2)(a)(c).

The enforcement action we took:
We have issued a warning notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Systems were not in place to ensure sufficient numbers of suitably qualified competent, skilled and experienced staff were employed and deployed. Regulation 18(1).

The enforcement action we took:
We have issued a warning notice against the provider.