Rosehurst Care Limited

# Rosehurst Care Home

**Inspection report**

162 Church Path
Deal
Kent
CT14 9TU
Tel: 01304 372312

Date of inspection visit: 27 and 30 January 2015
Date of publication: 31/03/2015

## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Inadequate |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection was carried out on 27 and 30 January 2015.

Rosehurst Care Home provides accommodation for up to 22 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted domestic property. Accommodation is arranged over two floors. A stair lift is available to assist people to get to the upper floor. The service has 16 single bedrooms and three double rooms, which two people can choose to share. There were 13 people living at the service at the time of our inspection.

The registered manager was not working at the service at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the care and has the legal responsibility for meeting the requirements of the law.

# Summary of findings

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We received concerns about the care received by people living at Rosehurst Care Home from whistle blowers and the local authority safeguarding team, so we inspected the service to make sure people were receiving safe, responsive and effective care and support.

We last inspected Rosehurst Care Home in October 2013. At that inspection we found the provider had taken action to meet the regulations that they were not meeting at our inspection in May 2013. The regulations related to the care and welfare of people who use services, safety and suitability of premises, and assessing and monitoring the quality of service.

Staff knew the possible signs of abuse; however some staff did not know how to report possible abuse. New staff had not completed safeguarding and whistleblowing training. Guidance was not provided to staff about how to identify and respond to safeguarding concerns. The provider did not know if they had put safeguarding or whistleblowing systems in place.

The provider did not have a system to ensure the service was provided by sufficient staff with the right skills and experience. Staff did not have time to spend with people and several people in the lounge and dining room received little interaction from staff during the day. At times staff were providing care to one or two people and were not available to keep the remaining 12 people safe. Cover for staff holidays, sickness and vacancies were provided by other staff members. Staff completed management tasks in their own time. Some staff told us they were tired because of the number of hours they were working each week.

Emergency plans such as emergency evacuation plans were not in place. Action had not been taken to minimise the risks to people from the environment. People were not able to call staff from communal areas such as the lounge. The environment had not been designed to support people to remain as independent as possible.

Some staff giving people their medicines had not received training. People were not always given their medicines at the time they required them. Systems were in place to ordered medicines but there were sometimes delays in obtaining new medicines. Guidelines for 'when required' (PRN) medicines were not accurate.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider was unaware of their responsibilities under Deprivation of Liberty Safeguards (DoLS). The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. The provider did not have a system to assess people's ability to make specific decisions where they may lack the ability to do so. Staff did not know who was able to make specific decisions for people when the person was not able to do so. Staff assumed that people were able to make decisions for themselves and supported them to do this.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. The provider had not obtained detailed information about staff's previous employment. Disclosure and Barring Service (DBS) criminal records checks had been completed.

The provider did not have a system in place to support staff to provide care safely and to an appropriate standard. Staff did not receive an induction to get to know the people and the care they needed when they first started working at the service. The provider did not have a system to ensure staff completed training to provide safe and appropriate care to people. People could not be confident that staff had developed the skills and knowledge to provide their care safely and effectively.

Care had not been planned to ensure that people remained well. Changes in the care that people needed were not recorded in people's plans of care and there was a risk care would not be provided as prescribed by the doctor or nurse.

People said they liked the food provided at the service. Meals included fresh vegetables and some homemade foods. Food was not prepared to meet people's specialist dietary needs. Staff did not know what each person preferred to eat and drink, their favourite food or foods they disliked. People had not always been referred to

# Summary of findings

appropriate health care professionals when they lost weight. Care recommended by healthcare professionals was not always planned and delivered to people to help them stay healthy. No system was in place to ensure people were offered drinks and snacks regularly during the day. People who needed pureed food were not able to taste the flavours of each food as it was pureed together. No choices were offered to people who required fortified, low calorie or pureed foods.

People were not always offered choices or were not offered choices in ways that they understood. Staff did not always respond to what people told them, and people did not always get the information they wanted. Staff did not always speak to people respectfully and did not always respect people's privacy.

People and their relatives had not been asked for information about their life before they moved into the service. When people were able to tell staff how they preferred their care provided, staff provided care as people wished. There was a risk that people who were not able to tell staff what they wanted would not have their needs met in the way they preferred.

Assessments of people's needs had been completed but changes were not been identified. Detailed guidance was not provided to staff about how to provide people's care and support. Staff did not always deliver care in the way it was planned.

People were at risk of isolation. Some people stayed in their rooms and had limited interaction with staff. Other people were isolated because of their communication difficulties. People were not supported to continue with interests and hobbies they enjoyed before moving into the service. A programme of activities was on display but this was out of date and most of the activities no longer happened.

People were happy to raise any concerns they had with the staff. People's relatives told us they had made complaints and the service had been slow to respond to their concerns. Information about how to make a complaint was displayed; however, this was not written in a way that people could easily understand.

The staff did not know what the aims and objectives of the service were. Care and support was not provided in the way described in the provider's statement of purpose including respecting people's privacy and dignity, encouraging people to be independent and making sure people received a good quality service.

The provider was not aware of the shortfalls in the quality of the service and staff practice we found at the inspection. Systems were in place to check the safety of the service but checks had not been completed on the quality of the care people received. Checks on the quality of the service had not identified shortfalls in the management or delivery of the service. The provider had not obtained information from people, their relatives and staff about their experiences of the care.

Action had not been taken to monitor and challenge staff practice to make sure people received a good standard of care. A manager with the skills and knowledge to lead the staff effectively was not working at the service. Staff were not given responsibilities and were not accountable for the care they provided. Staff were not supported to keep up to date with changes in the law and recognised guidance.

Records were kept about the care people received and about the day to day running of the service. Some records could not be found easily whilst other records could not be found at all. Systems were not in place to make sure that records were kept securely and could be located promptly when they were required.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# 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?**

Inadequate

The service was not safe.

Staff knew the signs of abuse but staff had not received guidance about how to respond to safeguarding concerns.

Although there were enough staff with the right skills and experience to meet people's needs staff did not have time to spend with people.

Emergency plans were not in place. Risks to people from the environment had not been reduced.

Some staff had not completed medicines training. People were not always given their medicines at the time they required them. There had been delays in obtaining new medicines on occasions.

**Is the service effective?**

Inadequate

The service was not effective.

The provider did not assess people's ability to make decisions. Arrangements were not in place to check if people were at risk of being deprived of their liberty.

Food was not prepared to meet people's specialist dietary needs. People were offered drinks and snacks regularly during the day.

Staff had not received all the training they needed to provide safe and appropriate care to people.

**Is the service caring?**

Inadequate

The service was not caring.

People were not always offered choices or were not offered choices in ways that they understood.

People's privacy was not respected and staff did not always speak to people respectfully.

People and their relatives had not been asked for information about their life before they moved into the service. There was a risk that people would not have their needs met in the way they preferred.

**Is the service responsive?**

Inadequate

The service was not responsive.

Detailed guidance was not provided to staff about how to provide people's care and support. Staff did not always deliver care in the way it was planned.

People were at risk of isolation. People who stayed in their rooms had limited interaction with staff. People were not supported to continue with interests and hobbies they enjoyed before moving into the service.

# Summary of findings

People were happy to raise any concerns they had with the staff. The service had been slow to respond to complaints. Information about how to make a complaint was displayed, however, this not written in a way that people could easily understand.

**Is the service well-led?**

**Inadequate**

The service was not well-led.

Staff did not know the aims of the service. Care was not provided in the way described in the provider's statement of purpose.

The provider was not aware of the shortfalls in the quality of the service and staff practice. Checks on the quality of the service had not identified shortfalls in the management or delivery of the service. The provider had not obtained information from people, their relatives and staff about their experiences of the care.

A manager was not working at the service. Staff were not accountable for the care they provided.

Records about the care people received and the management of the service were kept. Records were not kept securely and could not be located when they were required.

# Rosehurst 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 27 and 30 January 2015 and was unannounced. The inspection team consisted of two inspectors on both days.

Before the inspection the provider completed a Provider Information Return (PIR). 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. We reviewed the information included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury.

We spoke with the local authority safeguarding manager who was leading the investigations into quality and safeguarding concerns and case managers who had met with people living at the service in the month before our inspection. They told us they were concerned about the management and leadership of the service, the quality of the care people received, the action the provider took when people's needs changed and Deprivation of Liberty Safeguards. We also spoke with commissioners who had completed a contract monitoring visit in January 2015 and had raised concerns about the leadership and management of the service, staff support and training and records. We looked at all of these areas during our inspection.

During our inspection we spoke with six people, 1 person's relatives, five staff and the registered provider. We looked at the care and support that people received. We looked at people's bedrooms, with their permission; we looked at care records and associated risk assessments for five people who needed a lot of care and support. We observed medicines being administered and inspected seven medicine administration records (MAR). We observed a lunchtime period in the dining room and lounge. We used the Short Observational Framework for Inspection (SOFI) because most of the people receiving care at the service had dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Rosehurst Care Home in October 2013 where no concerns were identified.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe. Comments included, "I do feel safe here. Staff are there if I need any help" and "The staff are marvellous. You cannot fault the home. They cannot do enough for you. I feel safe living here".

Staff knew the signs of abuse, such as bruising or a person being withdrawn; however some staff did not know how to report abuse to the provider, the local authority safeguarding team or the Care Quality Commission (CQC). Before our inspection staff had shared concerns with other people who reported them to CQC and the safeguarding team. The Provider Information Return (PIR) stated all staff had completed safeguarding training when they began working at the service and yearly after that. New staff had not received safeguarding and whistleblowing training when they began working at the service and other staff had not completed training in the past year.

Guidance and information about the systems the provider had in place to identify and respond to safeguarding concerns was not available to staff. The provider did not know if they had put safeguarding or whistleblowing systems in place. When the local authority safeguarding team informed the provider about safeguarding allegations, the provider had taken action to protect people from possible risks posed by a staff member.

The provider had not taken steps to identify the possibility of abuse and prevent it before it occurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us, "Staff always come in and check on us. I don't see them a lot, but they are always about somewhere". Another person said, "They do have a quick look to check we are alright". One person told us, "Staff always come when I ring the bell".

The provider had obtained information about a system to help them decide how many staff were required to provide the care people needed but had not used this to ensure there were sufficient staff with the right skills and experience available to meet people's needs at all times. The number of people using the service had reduced since December 2014 and the provider had reduced the number of staff working on each shift because of this. The provider had not considered the needs of people using the service when making the decision.

Staff told us that they did not feel there was sufficient staff on duty to meet people's needs. Staff did not have time to spend with people and several people in the lounge and dining room received little interaction from staff during the day. No system was in place for people in the lounge or dinning room to call staff if they needed them.

Six people needed two staff to provide their care, including washing and dressing, bathing and moving between their bed, chair and the toilet. At times staff were providing care to one or two people and were not available to keep the remaining 12 people safe.

Shortly before lunch we saw one person walk into the kitchen and take a banana. Staff were present in the dining room but did not check on this person to make sure they were safe in the kitchen. The person did not have the capacity to understand risks that the kitchen may pose to them. We observed the person eating the banana skin in the lounge, the person did not understand that this was not edible. No staff were in the lounge and we were unable to find a member of care staff to support the person. We told another member of staff about our concerns and they offered the person lunch in a calm and gentle way which the person understood. The person listened to the staff member and began to hand the banana skin back to them in small pieces. A care worker who had just walked into the room snatched the remaining banana skin out of the person's hand without speaking to them. The person looked distressed by this, stood up and walked away from both staff and the food which had been offered to them. We did not see the person eat their lunch.

People ate their meals in the lounge and dining room at lunchtime. No staff were in the lounge and people did not receive the support they needed and struggled to eat their meal independently. One person needed help to cut up their food, they did not try to eat their food until a visiting relative cut it up for them.

An apprentice had been working at the service for six months, they were providing personal care to people without the support of an experienced member of staff. The apprentice was not an extra member of staff on shift and had the same responsibilities as other care staff.

Cover for staff holidays, sickness and vacancies were provided by other staff members. There were two night staff vacancies. Some staff worked at the service completing management tasks or taking people out to do

# Is the service safe?

activities such as shopping or visiting a café in their own time and were not paid. Some staff told us they were tired because of the number of hours they were working each week. There was a risk that sufficient staff would not be available to provide people's care safely and effectively.

People's health, safety and welfare was not safeguarded because the registered provider had not taken action to make sure, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to provide the service. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A fire evacuation plan was in place. The plan was based upon another providers plan and referred to emergency support not available to staff at Rosehurst Care Home. Staff had not practiced the plan and there was a risk that staff would not know what action to take in an emergency. Plans were not in place to support people to safely leave the building in an emergency.

Accidents involving people were recorded. Approximately 60 accidents were recorded for January 2015. Falls risks assessments had been completed when people were at risk. These assessments did not provide guidance to staff about how to reduce the risk of the person falling. One person had fallen at least 20 times in January 2015, these were usually 'not witnessed by staff'. The action required to manage the risk was to check the person every 15 minutes. No actions had been taken to reduce the risk of the person falling, the 15 minute checks were not happening. One person's falls risk assessment stated, 'At high risk of falls. Will forget to use Zimmer'. This contradicted other information in the person's care plan which stated, 'I have a Zimmer that I do not use as it is more of a risk to me as I do not understand how to use it and have been known to trip over it'. Staff did not know why the person fell or how they support them to remain as independent and safe as possible. One staff member told us, "I don't know why they fall. It's just their balance. I don't know what we can do about it". One person told us they had a mat in the room that set the call bell off when they stood on it, to tell staff if they had fallen out of bed.

Risk assessments had not been completed and care had not been planned when people were at risk. People had lost weight; nutritional risk assessments were in people's care plans but had not been completed when they had lost weight. Care and support had not been planned to support people to remain healthy. Risks to people's skin had not been identified and action had not always been taken to keep people's skin as healthy as possible.

The provider had failed to take action identify, assess and manage risks relating to the health, welfare and safety of service users. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The heating was not working correctly in some bedrooms, portable radiators were in use. These were hot to the touch. Some action had been taken to reduce the risks to people from the radiators. However, action had not been taken to manage risks to specific people such as the risk of burns if a person fell against a hot radiator. Other areas of the home were very warm. People sitting in the lounge asked an inspector to open a window as they were too hot. A call bells system was fitted in people's bedroom to they could call staff when they needed them. No systems were in place for people to call staff from communal areas such as the lounge or dining room where people spent time long periods of time. Staff did not complete regular checks on people to provide the support they required.

The environment had not been designed to support people to remain as independent as possible. Areas of the home, such as the lounges were cluttered with lots of pieces of furniture. The placement of furniture was not planned to support people to be as independent as possible, a table was put next to one person rather than in front of them and they struggled to eat their lunch without spilling it. Another person balanced their cup of tea on their sandwich plate at tea time as a table had not been put within their reach. Action had not been taken to help people identify different areas of the home and remain independent, such as their bedrooms. Recognised dementia care research recommends the use of distinctive colours and signage to make doors stand out.

The provider had failed to ensure that people were protected against the risks associated with unsuitable premises, as the premises were not suitably designed and laid out. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regular checks on the environment and equipment had been completed. A refurbishment plan was in place to

Inadequate

# Is the service safe?

repair faults such as the broken tiles around the sink in one bedroom. Action had been taken to repair some faults or damage. A handyman was available and repaired faults. Environmental risk assessments had been completed and contained plans to manage identified risks.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. The provider had failed to obtain sufficiently detailed information about staff's previous employment, including a full employment history and the reasons for any gaps in employment. The conduct of staff in previous employment had not been robustly checked. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff. The provider did not have a system in place protect people from the risks posed by new staff with cautions or convictions.

People were not protected from the risks of receiving unsafe care because the provider had not taken action to make sure staff were fit and had the skills and knowledge they needed for their role. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some staff giving people their medicines had not received training to do this safely. People were not always given their medicines at the time they required them, for example 8am medicines given at 11am. The time people were given medicine was not recorded. Action was not taken to make sure medicines were effective and did not pose a risk to people because the time between doses was correct. Each staff who gave people medicine had been observed administering medicines once. The errors we found had not been identified during these observations.

None of the people were responsible for taking their own medicines. Systems were in place to make sure that regular medicines were ordered on time and returned to the chemist if they were no longer needed. There were delays at times in obtaining new medicines for people, one person had been prescribed medicine by a doctor at the weekend before our inspection but this had not arrived three days later and had not been followed up. Records were kept of the medicines people received.

Some people were prescribed medicines when they needed them (PRN). Records of when PRN medicines were not required or refused were not accurate. Guidelines were provided to staff about when some PRN medicines were to be offered to people. Some guidelines were out of date. One person's PRN guidelines said they held their own emergency medicine and knew when it was needed. This medicine was not with the person and was stored in the medicines cupboard. Staff did not know what the guidelines were and where to find them. One person was prescribed five PRN medicines. Guidelines were not given to staff about when to offer the person their medicines. There was a risk the person would not receive their medicine when they needed it. People's medicines were stored safely.

People were not protected against the risks associated with the unsafe use and management of medicines, because appropriate arrangements for the obtaining, recording, and the safe administration of medicines were not in place. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Cleaners were employed but areas of the service were not clean. Some people's bedrooms were not clean or free from offensive odours. Systems were not in place to ensure that all areas of the building and furniture were kept as clean as possible. There were crumbs in one person's made bed and on the floor in their empty bedroom. Other bedrooms had stained carpets and beds and strong odours.

Inadequate

# Is the service effective?

## Our findings

We observed people being offered choices in ways that they understood. Staff responded to the choices people made. People were able to choose where they spent their time and who with. Staff asked two people at lunchtime, "Would you two ladies like to sit together?" The people said they would and staff guided them towards two seats next to each other.

The provider did not have a system to assess people's ability to make specific decisions where they may lack the ability to do so. Staff did not know who was able to make specific decisions for people when the person was not able to do so. The provider did not know who could lawfully make decisions on a person's behalf or when they needed to make decisions, with others, in the person's best interests.

We observed people, including those living with dementia, making choices for themselves. Staff assumed that people were able to make decisions for themselves and supported them to do this. Staff monitored the safety of people who had decided to make unwise decisions, such as not using equipment to keep their skin healthy or not using equipment to keep them safe when they fell.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was not meeting the requirements of DoLS. Staff were unaware of their responsibilities under DoLS. They told us that they had completed standard authorisation applications for some people at the request of the local authority case managers. The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations.

Before our inspection we received information from the local authority that a DoLS authorisation was in place for one person. Staff did not know that the authorisation had an end date and they needed to apply for another authorisation before it expired. Staff did not know that the authorisation restricted the person's liberty and did not give them powers to provide personal care to the person. The authorisation had conditions requiring the service to put care plans and risk assessment in place for the person's care. Staff did not know that the authorisation had conditions on it. Risk assessments had not been completed and care plans had not been put in place. Guidance was not available to staff about how to support the person to remain as independent as possible and to make sure that restrictions placed upon them were not excessive.

The provider did not have a system to assess people's capacity or act, with others, in people's best interests. Systems were not in place to check if people were at risk of being deprived of their liberty. The requirements of DoLS authorisations were not complied with. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When staff first started to work at the service they did not receive an induction to get know the people and the care and support that they needed. One staff member asked us what an induction was and two told us they learnt 'on the job'. The provider had not provided information and guidance about the induction process to staff whose role it was to manage and support staff. Staff promoted to new roles did not complete an induction to ensure they knew and understood their roles and responsibilities and developed the skills they needed. People could not be confident that new staff had developed the skills and knowledge to lead or provide their care safely and effectively.

The provider did not have a system in place to ensure staff received training to provide care to people safely and to an appropriate standard. Some staff had completed basic training including moving and handling and infection control, however not all staff had completed this training. Staff did not have the skills they needed to communicate with people effectively. Staff told us that one person had difficulty hearing and they had to shout to enable the person to hear them. We heard staff shouting at the person. The person responded by shouting back at staff, "You don't need to shout at me. Don't shout at me". A visiting nurse spoke to the person in a clear loud voice. The person understood the nurse's questions and responded appropriately.

Some staff had completed dementia care training but did not demonstrate an understanding of dementia when providing people's care and support. Some staff did not provide information to people in ways they could understand. One person watched television on their own in the lounge. They were confused and concerned about what they saw and did not understand that it was fictional. They spoke to a staff member about what they had seen and

were looking for an explanation and reassurance. The staff member did not respond to the persons concerns and continued asking the person what sandwiches they would like for tea. The person did not receive an explanation or reassurance from staff.

Approximately eight staff had enrolled on Level 2 or 3 Diplomas in Health and Social Care. The provider did not know how many staff had completed diplomas or equivalent qualifications and to what level. No senior staff working at the service had Level 5 Diploma in Leadership for Health and Social care or equivalent management qualification.

The provider did not have a system in place to support staff to support staff to provide care safely and to an appropriate standard. Staff told us they did not feel supported, by the provider, to deliver appropriate care. Staff had not met with the provider or senior staff regularly to talk about their role and the people they provided care and support to. All staff had met with the deputy manager once in January 2015 but staff appraisals had not been completed.

The provider had failed to enable staff to deliver care to an appropriate standard as staff had not received appropriate training. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before our inspection community nurses told us that the service did not always identify people's changing health needs and contact them in a timely way when people required health care assessments. A record was maintained in the 'seniors book' when requests for visits were made to people's doctors and community nurses. The outcomes of the visits were also recorded in the 'seniors book'. Changes in the care the people needed was not recorded in people's plans of care and there was a risk care would not be provided as prescribed by the doctor or nurse.

Care had not been planned to ensure that people did not become unwell. One person had food allergies. Information was not available to staff to help them identify the signs and symptoms that the person was having an allergic reaction and the action they needed to take.

Staff gave people, who could make decisions for themselves, information and explanations about their healthcare and treatment options and any risks. One person was at risk of developing sore skin and wounds and had equipment to support them to keep their skin healthy. Staff had explained to the person why they needed to move regularly. The person had decided that they did not want to move regularly**.** Staff respected this decision and continued to offer the person regular support to move.

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they liked the food provided at the service. One person told us, "The food is good. We get enough to eat. There is more than enough". Another person told us "The food is very good. We have our own chef". Meals included fresh vegetables and some homemade foods such as puddings. Before our inspection a specialist nurse had met with one of the home's cooks and provided them with information about 'fortifying' food with additional calories for people who were at risk of losing weight. Some people were receiving fortified main meals. Staff did not know which people required fortified foods, and there was a risk that people would not be offered enough calories to support them to stay healthy. Low sugar foods were available for people with diabetes, including puddings made with reduced sugar ingredients. These reduced sugar puddings were also given to people who required additional calories. Food was not prepared to meet people's specialist dietary needs.

Staff did not know what each person preferred to eat and drink, their favourite food or foods they disliked. One staff member told us, "I do try and cater for what people want but it doesn't always work", and another said "I haven't been here long enough to work out what people's favourite meals are".

People's weight was monitored and their weights were recorded. One person had lost weight but the service had not taken action to understand why and had not referred them to appropriate health care professionals such as people's doctors or a dietician. Other people had been referred to appropriate health care professionals. Some people were offered the care recommended by the health care professionals such as food supplements. These people's care was not planned to ensure that people received a fortified diet with supplements and additional foods offered between meals.

Inadequate

# Is the service effective?

People had their breakfast when they got up. Lunch was offered at 12 noon and afternoon tea at 4:30pm. Staff told us that snacks were offered to people between meals. No system was in place to ensure that snacks were regularly offered to people. One staff member told us, “A snack went out at 2.00pm today”. Another staff member said, “No one gave out snacks today”. Supper was not offered to people between tea and breakfast. One staff told us, “People can ask for something else to eat between tea and when they go to bed if they want to”. Another staff member said, “People can always ask for something if they are starving”. One person had a poor appetite and preferred to be offered small portions of food often. Their food was only provided to them at meal times. Action had not been taken to ensure that everyone was offered food and drinks regularly during the day.

People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. The lunchtime meal on one day was chicken, potatoes and vegetables. Everything was pureed together and presented in a plastic bowl. People were not able to taste the flavours of each food. No additional seasoning was added to ensure the food was not bland. There was a risk that people would not eat the food because of the way it was prepared and presented. Some people were offered meals choices. However, no choices were offered to people who required fortified or low calorie foods or pureed foods.

People were not offered suitable and nutritious food in sufficient quantities to meet the needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inadequate

# Is the service caring?

## Our findings

People told us the staff were 'kind', 'polite', 'lovely' and 'patient'. One person told us, "The staff do anything I ask", another person said, "The staff look after me well". One person's relative said the care their relative received was 'impersonal' and not specific to their needs.

Staff did not chat to people or provide them with information about the care and support they were providing. People in the lounge were not reminded what they were having for lunch as they were served. There were long gaps between each person being served. Some people had finished their meal before others had been served. Staff did not tell people when their meal would be served. One person watched four people eat their lunch and asked an inspector, "Can I have something to eat please?" We told staff the person had asked for their meal and they were served quickly, however, staff did not apologise for the delay or tell the person what they had for lunch.

Staff did not listen to people. One person, who had difficulty speaking, spoke to staff as they were served their lunch. Staff did not understand what the person had said and so did not respond accordingly. The person became frustrated and repeated what they had said. Staff repeated the answer they had previously given. When the staff left the room the person became angry and began shouting. The person told us they needed to go to the toilet. We asked staff to support the person to use the toilet.

Staff did not treat people with respect. On both days of the inspection we observed staff standing next to people who were seated while supporting them to eat a meal. Staff did not speak to people as they helped them. We would expect staff to sit next to the person, provide them with information and ask how they would like their support to be provided. Staff walked away from people and completed other tasks whilst supporting people with their meal, such as answering the phone. People had to wait for staff to return to continue their meal.

One member of staff was helping a person prepare to eat their meal. The staff member asked the person, "Shall I get you a bib? Do you want a bib? I'll get you a bib". The person shouted at the staff member as they left the room but the staff member did not acknowledge them. Other staff answered people's questions and responded to their requests appropriately.

On occasions staff treated people kindly and people appeared relaxed in the company of staff. Some staff had good relationships with people, chatting to them about their lives and asking questions about their past. We observed people and staff chatting about the type of prams they had for their children and shared information of their experiences. People were asked for suggestions for baby names and what their children were called.

Personal choices and preferences were not always supported. One lady told us said that a male carer had helped them to have a shower. They said that they were a bit worried about this, but he was very kind. People's choice about the sex of the staff member they preferred to help them with their personal care was not included in people's care plans. On occasions people were offered choices in ways that they understood. One staff member offered people choices of sandwiches at teatime and showed them the sandwiches so they could see the options.

One person's relative told us they did not think that staff knew their relative well. People and their relatives had not been asked for information about their life before they moved into the service. Three of the five care plans we looked at did not contain information about people's life history. The care plan for one person who had lived at the service for 5 months instructed staff to find out about their life history. This information was not included in their care plan and staff did not know about parts of the person's life such as their past occupation. When people were able to tell staff how they preferred to be helped with their care, staff provided care as people wished, such as when they wanted to get up and equipment they liked to use. There was a risk that people who were not able to tell staff what they wanted would not have their needs met in the way they preferred.

People's privacy was not maintained. Personal, confidential information about people and their care and health needs was not kept securely. Staff wrote notes in people's care plans at the dining room table, plans were not put away when they had been completed. Other confidential information was displayed on noticeboards or stored on the medicines trolley. People's personal information was

Inadequate

# Is the service caring?

accessible to other people and visitors to the service. Staff described to us how they maintained people's privacy when they provided personal care but had not recognised that people's information was not kept confidential.

The provider had not taken action to make sure that people were treated with respect and had their views taken into consideration. People were not given privacy. People were not supported to make or participate in making decisions about their care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no restriction on people's family and friends visiting the service. People and their relatives told us that they visited often.

Inadequate

# Is the service responsive?

## Our findings

Three people we spoke with did not know that the staff had written a plan about how their care would be provided. Everybody we spoke with was happy with the support they received from staff and accepted what staff did for them. One person said, "I just go along with what they say". One person's relative told us they and their relative had not been involved in developing the person's care plan and they had not seen it.

People were at risk of isolation. Some people stayed in their rooms and had limited interaction with staff. Other people were isolated because staff did not have the skills to communicate with them. Staff sat one person in a wheelchair at a dining table facing a wall at approximately 10.30 am, the person was sat in the same place when we left at approx. 5.30pm. Staff only spoke to the person as they walked past to check if they were OK and then walked away.

Assessments of people's needs had been carried out before they moved in to the service. Information had been obtained from other service providers or commissioners before people were offered a care service. Some further assessments had been completed once people begun to receive a service but changes in people's needs had always not been identified and care had not been planned to reflect the changes. One person's plan instructed staff to weigh the person fortnightly and inform their doctor of any weight loss. The person had refused to be weighed for eighteen months. Action had not been taken to measure any weight loss and gain another way to ensure that the person was safe.

Care plans did not reflect how people would like all their care to be provided by staff. Detailed guidance was not provided to staff about how to provide people's care and support. One person had difficulty hearing. Their communication care plan did not inform staff that the person had difficulty hearing or guide them in how best to communicate with the person. When care had been planned for people staff did not provide the care in the way it was planned.

Staff told us that they did not have time to read the care plans and relied on other staff to tell them how care should be provided. One person had their meal placed in front of them, but did not try to eat it. Staff told us the person did not need support with their meal unless they were unwell. Staff told us earlier in the day that the person had a lay in that morning as they were unwell. Staff did not check if the person was eating their meal. After 15 minutes a staff member asked the person if they felt unwell, the person said they did, and the staff member helped them. The person's care plan instructed staff that when the person felt unwell they required help with their meals. On this occasion staff had not told each other the person felt unwell and had not checked to ensure the person was eating their meal.

One person told us, "Staff understand and know me". Another person told us they liked to get up early, this was recorded in their care plan and staff supported the person to get up when they chose.

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had little opportunity to follow their interests or take part in social activities. Staff told us that people needed more stimulation and things to do but they did not have the time to spend with people. A programme of activities was on display but this was out of date and most of the activities no longer happened. People spent their time either watching the television or doing nothing. One person's care plan said they enjoyed listening to music and spending one to one time with staff, the person had not been given the opportunity to participate in these activities. Some people very occasionally went out to the shops or for a drink, staff supported them to do this in their own time. An exercise therapist visited during the inspection and people enjoyed this activity. A 'Pets as Therapy' (PAT) dog visited the service once a month, which people liked.

The four people we spoke with said they were happy to raise any concerns they had with the staff. One person said, "The owner is around more, he's a nice man and really friendly". One person's relative told us that they had complained about different areas of their relatives care. They told us that they had complained several times about each issue before staff took action to resolve their concerns. Information about how to make a complaint was displayed, however, this not written in a way that people could easily understand.

Inadequate

# Is the service well-led?

## Our findings

The provider did not have a clear set of values and behaviours they required from staff, such as compassion and respect. The provider's statement of purpose which was not available in the service stated its aim was 'to provide long term care using a holistic approach' by providing 'a caring, safe, warm, stimulating and supportive environment'. Staff did not know what the aims and objectives of the service were when we asked them. We found that the provider was not meeting their aims. The provider had not taken action to ensure staff promoted a culture of independence and involvement of people.

The provider had not identified the concerns about staff practice that we found. Staff had not received information and guidance about how to provide safe and effective care to meet people's individual needs. Action had not been taken to monitor and challenge staff practice to make sure people received a good standard of care. Staff told us they did not know how to contact the provider if they had concerns about the service or leadership. They told us the deputy manager and some senior care staff were helpful and supportive.

A manager with the skills and knowledge to lead the staff effectively was not working at the service. Staff told us recent changes in the leadership of the service had made the atmosphere more relaxed. One staff member told us, "I used to hate coming in to work". Another staff member said, "Staff have more time and are not pressured now". One person's relative told us, "Things at the service have fallen apart. The right hand doesn't know what the left hand is doing. Communication is not always good between staff and information is not passed on from one staff member to another".

Staff's responsibilities were not clear, such as who was leading each shift. Staff were not given responsibilities and were not accountable for the care they provided. Two staff were completing people's food records. One staff member asked the other how much one person, who was at risk of losing weight, had eaten. The second staff member, who had helped the person eat their meal replied, "I don't know, put about 90 percent".

The provider was not aware of the shortfalls in the quality of the service found at the inspection. Systems were in place to assess the quality of the environment and health and safety procedures but checks on the quality of the care people received had not been completed. Reviews of care records had not identified the shortfalls in assessments, care planning and care delivery that we found. The provider had employed an outside organisation to complete checks on the quality of the service. The check completed in September 2014 did not identify shortfalls in the management or delivery of the service. Following the changes in the management of the service in January 2015 a further check was completed and staff and people were spoken with. The shortfalls in compliance with regulations we found at the inspection were not identified as part of this check.

Staff were not supported by the provider to keep up to date with changes in the law and recognised guidance. The provider's statement of purpose states, 'All staff is kept updated with new and revised policies and procedures and also any new/revised regulations and standards from the Care Quality Commission (CQC)'. Staff we spoke with who had been employed since the last CQC inspection did not know about CQC, our role and responsibility. Staff were not aware of changes in the way we inspected services. Staff did not know the processes the provider had put in place to manage and deliver the service. Polices and guidelines for staff were not available in the service on the first day of our inspection. The provider had provided copies by the second day of our inspection but staff had not read them.

The provider did not know what training staff had completed and if refresher training was required. A plan was not in place to ensure that staff developed the skills and knowledge they needed to meet people's needs safely and to an appropriate standard.

Systems were not in place to ask people and their representatives for their views to reduce the risks of people receiving inappropriate or unsafe care. People had not been asked for their views on the care they received. Systems were not in place to obtain the views of staff and other professionals involved in people's care, such as people's nurses and doctors, on the quality of the care people received.

People were not protected against the risks of inappropriate or unsafe care because the provider did not have a system in place to regularly assess and monitor the quality of the service. The views of people, their families and friends and staff were not regularly sought to enable

Inadequate

# Is the service well-led?

the provider to come to an informed view about the standard of care provided to people. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were kept about the care people received and about the day to day running of the service. Some records could not be found easily whilst other records could not be found at all. The provider told us they were unaware if many of the records we asked to see during the inspection, including safety checks, and care records existed. They said that they were unable to look for them as they were stored in the cellar of the premises. A system to archive records so they could be retrieved easily was not in operation. The provider told us that when they have visited the service in December 2014 they found that records relating to all areas of the service were muddled and had not been filed. They told us that they did not know what records had been completed. Systems were not in place to make sure that records were kept securely and could be located promptly when they were required.

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them. An accurate record in respect of each person and other records in relation to staff and the management of the service had not been kept. Records were not kept securely and could not be located promptly when required. This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>Sufficient numbers of suitably qualified, skilled and experienced staff were not employed to safeguard the health, safety and welfare of service users.<br><br>Regulation 22 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>People were not protected against the risks associated with the unsafe use and management of medicines, because appropriate arrangements for the obtaining, recording, and the safe administration of medicines were not in place.<br><br>Regulation 13 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>The provider did not have a system to assess people's capacity to make specific decisions and act, with others, in people's best interests. Arrangements were not in place to obtain and act on the decisions of people lawfully able to make decisions on a people's behalf. Systems were not in place in place to check if people were at risk of being deprived of their liberty and apply for a DoLS authorisation. Arrangements were not in place to comply with the requirements of DoLS authorisations made.<br><br>Regulation 18(1)(a)(a)(2) . |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse<br><br>The provider did not have systems in place to protect service users from the risk of abuse.<br><br>Regulation 11(1)(a)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br><br>The provider had failed to enable staff to deliver care to an appropriate standard as staff had not received appropriate training.<br><br>Regulation 23 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe.<br><br>Regulation 9 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>People were not offered suitable and nutritious food in sufficient quantities to meet the needs.<br><br>Regulation 14(1)(a) |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>People were not treated with respect and had not their views taken into consideration. People were not given privacy. People were not supported to make or participate in making decisions about their care.<br><br>Regulation 17 (1)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br><br>The provider had failed to ensure that service users are protected against the risks associated with unsafe or unsuitable premises, as the premises were not suitably designed and laid out.<br><br>Regulation 15 (1)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br><br>The provider had failed to ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. An accurate record in respect of each service user and other records in relation to staff and the management of the service had not been kept. Records were not kept securely and could not be located promptly when required.<br><br>Regulation 20 (1)(a)(b)(i)(ii)(2)(a) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>**10(1)(a)(b)(2)(c)(i)(e)** |

**The enforcement action we took:**

CQC has issued a formal warning to Rosehurst Care Limited telling them that they must improve in the following areas by 30 April 2015.

The provider was not protecting people against the risks of unsafe care and treatment by not effectively assessing and monitoring the quality of service provided.