Twilight Healthcare Limited

Rosehaven Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 20 & 30 June 2016 and was unannounced. The service was last inspected on 16 September 2014. They met the requirements of the regulations during that inspection.

Rosehaven Care Home is registered to provide accommodation for up to 24 older people. The home is situated close to Stanley Park and local community facilities. Communal accommodation consists of two lounges on the ground floor and a separate dining room. Bedroom accommodation is situated on the ground, first and second floors. An en-suite facility is provided in nine of the bedrooms. There is a passenger lift for ease of access throughout the building.

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

Not all the people in the home were able to converse easily with us. Therefore, we also observed care and staff interactions with people and spoke with people's relatives. People able to talk with us told us they felt safe and well cared for. However, the care practice we saw did not always indicate this. Care practice was not always safe. Highly dependent people were left unsupervised. There were not enough members of staff available to support people safely and staff were not deployed in an effective way.

There were significant periods of time where people in both lounges, were left unsupervised, unsupported, unstimulated and inactive. More dependent people had limited interaction from staff and no social or leisure activities. Staff interaction was mainly to assist with meals or drinks. We observed three people in one lounge who were very dependent. They were unsupervised, with little stimulation or attention for long periods of time. There was more supervision in the other lounge, but this was still limited.

We looked at how medicines were prepared and administered. We saw 'when necessary' medicines were not always given as prescribed or as needed. Information about foods that adversely interacted with certain medicines were not recorded on MAR sheets or nutritional care plans. Failing to give people their medicines properly placed the health and welfare of people at unnecessary risk.

We looked at the recruitment and selection procedures the provider had in place to ensure people were supported by suitably qualified and experienced staff. We looked at the recruitment records of six members of staff. Suitable arrangements were not always in place to ensure safe recruitment practices were followed.

People told us that staff were caring and kind. They and their relatives said that staff were patient and compassionate. However, care practices were not always safe and had the potential to or caused harm to people. Although staff were pleasant, they did not focus on the wellbeing of more dependent people.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), was not implemented. People had not consented to or been involved in planning and updating their care. People's mental capacity had not been assessed. The registered manager had not applied for a DoLS for anyone in the home even for those who would meet the criterion for a DoLS because of their lack of capacity. The registered manager had met with the local authority for advice when we inspected, but had not started the DoLS process. They did not have a working knowledge of the MCA.

Care planning was not personalised. Neither were care records always accurate or up to date. Choices of when to receive personal care and support were limited by the staff routines. These were task centred rather than in response to people's individual needs and preferences. Social and leisure activities were not in place.

People, relatives and staff told us they found the registered manager supportive and approachable. One person told us, "She is lovely. I can always have a few minutes talking to her." However, we found the home was not well led and the registered manager was not fully aware of their responsibilities as the registered person.

There were procedures in place to monitor the quality of the service. However, the audits were not consistently completed. Neither had the audit systems identified the areas of concern found during this inspection.

There was good dementia signage around the home. Communal areas were clean and tidy and bedrooms were clean and personalised. However, not all bedroom windows could be opened and window frames throughout the home needed attention.

People were complimentary about the meals and told us they enjoyed them. People were offered a choice of nutritious meals.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Although people told us they felt safe staff were not providing consistently safe and appropriate care to people.

Staffing levels were not always sufficient or staff deployed safely. People were left unattended, with little stimulation or attention for long periods of time.

'When necessary' medicines were not always given as prescribed or needed.

Is the service effective?

Inadequate

The service was not effective.

People had not consented to care. Procedures were not in place to enable staff to assess people's mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

Advice from other professionals was not always sought and care and treatment was not always carried out as directed.

People were offered a choice of nutritious meals. People we spoke with told us they enjoyed their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always provided with care and supervision.

There was no advocacy involvement for people with limited mental capacity to assist with decision making

Staff spoke with people in a respectful way and people said that staff respected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not personalised and support and supervision was infrequent. There were no social and leisure activities in place.

Care plans and risk assessments were in place, but not all the information was accurate, or it was out-of-date or missing.

People we spoke with said they had not made any complaints, but felt they would be listened to and concerns would be acted upon.

Is the service well-led?

Inadequate

The service was not well led.

The management team did not ensure that care was safe and person centred or that staff were deployed effectively.

Audits were not carried out consistently and were not highlighting the areas of concern identified during this inspection.

The registered manager did not show all the necessary skills and knowledge to manage effectively. They were not fully aware of their responsibilities as the registered person.

Rosehaven Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 & 30 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We spoke to the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced whilst living at the home.

During our inspection we spoke with a range of people about the service. They included six people who lived at the home, six relatives, the registered manager, six members of staff and health care professionals. We spent time observing the care and support being delivered throughout the communal areas of the home. We also 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 looked at the care and medicine records of four people, the previous four weeks of staff rota's, recruitment records for six staff, and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People who lived at the home who were able to converse with us told us they felt safe at Rosehaven. However, there was a mix of views from relatives. Although relatives said they felt their family member was safe, they expressed concerns over the lack of monitoring and supervision of more dependant people. These concerns reflected our observations of more dependent people being left unsupervised for long periods of time.

Staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. However people were not kept safe. People with high care needs were left unattended for long periods of time. This left staff unaware about their safety or well-being. One person was found to have a serious injury after being left unattended. Staff were told by visitors that the person had slipped from the chair. However, it was not known if this was the cause of the injury. Neither CQC nor the local authority safeguarding team had been informed of this.

We looked at care records which identified two people who lived at the home had suffered bruising when being moved. We spoke with the registered manager about this. We saw action had been taken to keep people safe but the provider had failed to inform the safeguarding authority to enable effective investigations to take place.

We made four safeguarding alerts to the local authority safeguarding team because of concerns we found during our inspection about how people were cared for in Rosehaven.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to protect people from abuse and improper treatment.

We looked at the care plans of two people whose behaviour challenged the service. They were on occasion verbally aggressive, damaged furniture, non-compliant with care or disturbed other people who lived at the home. Staff failed to identify or record triggers for these behaviours. There were no management strategies in place or information of how to defuse situations or distract people from behaviour that challenged. There were no risk assessments identifying the behaviours and how to minimise risks.

We observed staff interactions with people who lived at the home including the two people whose behaviour challenged the service. We saw no meaningful engagement by staff during the inspection. Social interaction or activities were not provided. We spoke with the registered manager. They had referred one person to other professionals for advice, but had taken no action to identify the reasons for the behaviour.

Although risk assessments for falls, moving and handling, nutrition and pressure care were completed, these were not personalised and did not show how the individual risks were to be reduced. Falls had been audited to highlight the number of falls people had and to identify accidents. However the reasons for accidents were not always evaluated or action taken to reduce the risk of further injury.

We saw in one person's care records a member of staff had transferred a service user unsafely by manually moving them on their own. This was instead of using a hoist with the support of another member of staff. This transfer had caused bruising on the person's arm.

Another person's care records recorded they had frequent and recurring 'sore skin' over a four week period in June 2016. However there was no record of a request for advice on the treatment and management of this. Neither was there a care plan relating to pressure area care. During the inspection visit we saw the person was not assisted by staff to change position and move around to relieve pressure or to promote their independence.

These are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to carry out appropriate assessments to mitigate risks to people.

We looked at how medicines were administered. We observed a medicines round and saw that the member of staff signed for medicines immediately after they had given them to people, so it was clear they had received them. Medicines were ordered appropriately, checked on receipt into the home and stored and disposed of correctly. Staff informed us there was no one who had covert medication. Covert medication is medicines given without the person's knowledge or agreement. We saw that the temperature of the medicines fridge was regularly checked and recorded. This kept medicines at the correct temperature.

People who had medicines administered by care staff all said they received it on time. However, we saw that 'when necessary' medicines were not always managed appropriately. Two people had limited mental capacity. Staff asked them if they wanted pain killers without any explanation and accepted a 'no' without further discussion. This was despite one person who exhibited signs of pain. Staff later said to the person, "You can have some pain relief after tea." The member of staff told us this person frequently had discomfort. We looked at the medicines record and saw the person had only received pain relief at lunchtime and teatime during the past month prior to the inspection. There was no pain relief tool in place to assist staff to identify when people were in pain and staff said they checked pain by observing the person. However, we observed staff were not always monitoring people during the inspection.

In two of the four files checked there was a record on a separate medication profile in the care records that the person was not to have grapefruit because it interacted with their medicines. These were not dated or signed. There was no reference to this either on the person's nutritional care plan or MAR sheet. This increased the risk of staff unintentionally giving people food that could have a harmful effect on them.

Two people were prescribed medicines that were harmful to them if taken with grapefruit or grapefruit juice. Grapefruit and grapefruit juice can affect a number of medicines. They affect the rate at which drugs are processed by the liver and lead to high blood levels of medications causing adverse effects.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure people received their medicines safely and when they needed these.

We looked at how Rosehaven was being staffed. We did this to see if there were enough staff on duty to support people throughout the day and night. We looked at previous staff rotas as well as observing staffing on the inspection. We asked people who lived at Rosehaven if there were enough staff on duty. One person said, "It takes a while to find anyone." Another person sat in a lounge told us, "There isn't always one of them [staff] about. You have to wait until they come in here." Relatives told us they often had a problem finding a member of staff. One person said, "The staff are rarely in the lounge with people. We often can't

find anyone." Another relative told us "There is not often any staff with [our family member]." This reflected the inspector's findings as there were two occasions where they were unable to find staff for over ten minutes and had to go looking around the home for them. The inspector sat in a lounge for several hours. During this time staff only went into the lounge to assist with meals or medicines or briefly looked in.

The registered manager said there had been staffing difficulties, but stated things were getting better and they met the needs of people. Staff told us they felt there were usually enough staff to support people. However this was not our experience. Staffing was not meeting the needs of people and staff were not deployed in an effective way. There was limited interaction with people and we saw one person waiting over ten minutes for a member of staff to go into a lounge so they could request assistance to the toilet. We observed the care and support three people received for over six hours. They received no attention or stimulation other than meals during this time. One person was intermittently shouting then sleeping, another person was clearly in discomfort writhing and groaning intermittently. The other person sat passively or dozed. There was no music, no TV, no activity and minimal interaction from staff.

Rosehaven is registered with the Care Quality Commission (CQC) to support older people whose predominant needs were those related to general ageing. However, the registered manager said six people had care needs predominantly related to dementia. The registered manager said 12 people needed two staff to support them, and other people needed some help with personal care.

The environment took into account the needs of people who lived with dementia with signage to assist people to orientate themselves around the home. However, staff were not deployed to effectively support people living with dementia or high care needs. They were left unattended and unsupported and did not receive safe care. There were no measures to improve wellbeing and independence for people living with dementia, no activities or staff engagement.

Although staff told us they had received basic dementia awareness training, this had not translated into good practice and did not meet the needs of people living with dementia. Management and staff were not equipped when we inspected to provide for the complex needs of people living with dementia.

These are breaches of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to deploy sufficient numbers of suitably competent and experienced staff to make sure that they could meet people's care and treatment needs.

We looked at the recruitment and selection of six members of staff. Disclosure and Barring Service (DBS) Checks had been received before new staff were allowed to work in the home. These checks were introduced to stop people who have been barred from working with vulnerable adults being able to work in such positions. However other checks had not been fully completed. People who lived at the home were not protected from unsuitable members of staff working in the home because safe recruitment procedures were not followed. There were gaps in the application forms and discrepancies in employment histories that had not been followed up. This reduced the information the management team had of the prospective staff members' work histories. Contrary to the homes recruitment policy, two references including one from the most recent employer had not been received before four applicants were allowed to work in the home. One applicant had no references, whilst another had only one. Two staff had two references from friends or colleagues only, not from their employers. We spoke with the registered manager about the poor recruitment checks. She was unable to offer an explanation for them.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to operate safe and effective recruitment procedures to ensure that persons

employed were of good character.

Records were available confirming gas appliances and electrical facilities complied with statutory requirements and were safe for use. Equipment had been serviced and maintained as required. Legionella checks had been carried out. We checked a sample of water temperatures. These were delivering water at a safe temperature in line with health and safety guidelines.

A fire safety policy and procedure were in place, which clearly outlined action to be taken in the event of a fire. People had personal evacuation plans in place. A fire safety risk assessment and equipment checks had been carried out so the risk of fire was reduced as far as possible.

There was a rolling programme of redecoration and any repairs needed were recorded for the maintenance person to complete. Refurbishment of a bathroom was ongoing. However people told us this was taking a long time. Redecoration of the home had also started, but we could see window frames throughout the home needed attention. People also showed us where bedroom windows would not open, which resulted in rooms being hot and stuffy. The hot water tap in one bedroom was not working. We saw there was a clean and fresh smell in most areas of the home and it was clean and tidy. Staff wore personal protective clothing when involved in personal care and at mealtimes, which assisted with reducing cross infection.

Inadequate

Is the service effective?

Our findings

People told us staff organised for the GP and other health professionals to visit if they were unwell. We saw evidence the home had been pro-active in arranging speech and language therapy for one person and taken them to speech therapy sessions. This had assisted in a noticeable improvement of the person's ability to communicate. GP and district nurse visits had been arranged as had optician and chiropody appointments. This helped people to access the health support they needed.

However, we saw appropriate referrals were not always made where people needed GP or district nurse or hospital advice and treatment. After a reported accident, unwitnessed by staff, one person had shown signs of injury, and complained of pain. Despite this the registered manager had not followed the advice of the GP to arrange checks and treatment for the person. They were not taken for checks and treatment until five days after the injury, where they were found to have a fractured shoulder. The registered manager told us she felt the person would get upset if taken to hospital so waited to see how she was.

These are breaches of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had disregarded the needs of the person for care or treatment.

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). 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 MCA was not implemented in any formal way. There were no records of any MCA assessments or best interests' decisions having been undertaken. We asked the registered manager how she had implemented the MCA in the home. The registered manager told us she had not formally implemented the MCA. We looked at care records. We found appropriate arrangements had not been made or records kept in regards to mental capacity. There was no documentation where there were concerns about a person's ability to make decisions for themselves, or to support those who lacked capacity to manage risk. The registered manager had completed documentation where people's rights were restricted such as with locked external doors and bedrails. However the registered manager had not involved the individuals or other relevant people in these decisions.

Although the home had policies in place in relation to the MCA and Deprivation of Liberty Safeguards (DoLS), the registered manager and management team had not determined people's capacity or applied for DoLS approval. There was no information recorded to suggest whether people had mental capacity to make decisions.

The registered manager told us no one had a DoLS, despite there being a number of people who lived at Rosehaven who would meet the criterion for a DoLS because of their lack of capacity. On the second day of inspection the registered manager told us she had been shown how to complete a DoLS application the previous day although she had not yet done so.

We spoke with five staff to check their understanding of the MCA and DoLS. They were aware of the Mental Capacity Act, but were not involved in implementing this. Neither did they know how this was implemented in the home.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had deprived people of their liberty unlawfully.

We talked with people and looked at four care records to see if people had consented to their care where they had mental capacity. People said they had not been involved in decisions in their care. One person said, "Consent, I don't think so. I just let the girls get on with it." There was no overall or decision specific consent documented in people's care files. We asked the registered manager if people had consented to their care. She told us they had not in any formal way. We asked if people had received support to make decisions where they had capacity or if best interests meetings had been held regarding decisions where people did not have mental capacity. The registered manager said this had not yet happened. We saw a document that stated a person who did not have capacity had no one to act on their behalf. However the registered manager had not involved an advocate or arranged best interests meeting regarding decisions made.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to gain the consent of people to provide care and treatment.

Staff we spoke with told us that they had frequent training. We saw two staff records showing that staff had completed training including moving and handling, fire, dementia care, food hygiene and diabetes care. We asked for a training matrix to check the training information for other staff. The registered manager said this needed updating and would send this to CQC, though we did not receive this. It was evident that where dementia and MCA and DoLS training had been provided this had not carried through to care practices.

We spoke with people about the food provided and observed the lunch and evening meals. People were complimentary about the meals and told us they enjoyed them. One person said, "Yes, the food is usually pretty good. I am quite satisfied." Another person told us, "I enjoy most of the meals and we have a choice." Relatives told us the food looked good and their family members enjoyed it.

We observed lunch and evening mealtimes. Three people who needed full assistance with their meals had them before other people. They remained in the armchairs for their meal. They were not supported to have a change of position to help with comfort when eating or with pressure area care. Staff were pleasant and talked with people they were assisting.

At lunch, we saw one of the three people was sleeping and difficult to rouse. Staff took the meal away uneaten. However, daily records did not refer to the person sleeping and not eating the meal or if they were given a lunch later. Several people ate in the dining room or in a lounge once the small group of people had been assisted to have their meal. We saw mealtimes were busy with staff toing and froing with meals.

We spoke with the cook who showed us the kitchen, which had recently been refurbished. It was clean and tidy and well organised. Frequent temperature checks of food and of fridges and freezers were carried out

and recorded. They showed us the new crockery which contrasted with the dining tables and assisted people with dementia to differentiate between the different foods and tableware. We found meals were freshly cooked and presented to a good standard. The cook told us they were not restricted on the amount or type of foods they could buy and any equipment they needed was provided. The cook and care staff were familiar with how to thicken fluids and to fortify foods where people needed extra calories to assist them to gain weight.

One member of staff was unhappy with the management support and management style in the home although other staff spoken with told us they felt well supported through supervisions and the staff meetings. We saw records of recent formal supervision. This is where individual staff and those concerned with their performance, typically line managers, discuss their performance and development and the support they need in their role. It is used to assess recent performance and focus on future development, opportunities and any resources needed. We saw there were also occasional staff meetings.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were very caring and kind. One person told us, "They've been very kind and have really helped me." Another person said, "I can't fault them. They are very good." A relative said. "The girls are brilliant, they are lovely but they are always busy. There is not often anyone in the lounge or anything going on for the residents."

We spent time in all areas of the home, including the lounge and dining areas. This helped us observe the daily routines and gain an insight into how people's care and support was managed. We saw that although staff were friendly when assisting people, interaction was infrequent.
Staff did not focus on the well-being of more dependent people. Three people who were highly dependent were left in their armchairs all day, including mealtimes. For a total of over six hours staff presence was extremely low. Staff were not effectively organised to ensure there was a staff presence to oversee people in the lounge areas. There were significant periods of time where people were left with no stimulation or activity, and were unsupervised and unsupported.

We saw in the care records we looked at people's end of life wishes and preferences had not been recorded or acted upon. This left staff unaware of any specific spiritual, cultural or personal wishes they had as they moved towards the end of life. This did not enable them to be proactive when issues arose.

The registered manager told us that people had used advocacy support in the past. However we did not see any information available about local advocacy services. We were told one person had no relatives and limited capacity. We looked in their care records to identify the help staff had arranged to assist the person in decision making. There were no records relating to this. We asked the registered manager whether advocacy support had been used to assist the person with decision making. She told us there had been no advocate involved to act on behalf of the person. Therefore the person had not been appropriately supported in any choices.

We recommend that the provider arranges advocacy support for people who have limited mental capacity to assist with decision making, where they have no one to advocate on their behalf.

We saw several good staff interactions with people. We saw two staff supported a person who lived at Rosehaven. They explained what they were doing and why. They did not rush the person and chatted with them as they supported them. We saw another person laid on a sofa in the lounge. Staff placed a blanket over the person as they were feeling a little cold, smiling at them as they did so.

When staff interacted with people they spoke with them in a respectful way. People told us staff respected their privacy. One person said, "They stand outside the door when I use the toilet, so I can have a bit of privacy." We saw staff knock on bedroom and bathroom doors to check if they could enter. People felt they could trust staff and they were friendly and respectful.

The home had a variety of leaflets available in the entrance hall for people. These included: choosing a care

home, complaints, dementia, strokes, terminal illness and lesbian, gay, bisexual and transgender (LGBT) friendly care services information. This gave people access to useful information to assist them with health and equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

We found people did not experience a level of care and support that promoted their wellbeing or quality of life. Interaction, although friendly, was infrequent and people were socially isolated and unstimulated. People and their relatives told us staff were nice and friendly, but said there were often few staff about and there were no activities. One person said, "There isn't much to do. We just sit in here [the lounge]." A relative told us, "The personal care is good, but there are few staff and rarely any activities or anything." Staff told us they did activities when they could, but the activities coordinator had left and they were waiting for the new activities coordinator to start in their new role. The registered manager told us a member of staff would move from a care role to activity coordinator, but they were unable to move until a new care staff had been appointed.

We asked people about social and leisure activities. People told us there were rarely any activities available. One person said, "Sometimes I watch television –not much else." Although staff told us they sometimes had activities there were none when we inspected. Where people were unable to occupy themselves unsupported, this made for a long and unstimulating day. The lack of meaningful social contact and companionship also increased social isolation and loneliness.

We looked at care plans and observed care and staff interactions for people who lived at the home. Staff were not following care plans or providing care that met people's needs. In one person's care plan it stated 'needs constant supervision, mobility should be encouraged'. Another stated 'has vascular dementia, should be monitored closely.' This did not happen during the inspection. Another person's care plan recorded '[person] Does not like to be alone enjoys conversation. Staff should try and take time to talk and reassure [person].' However, through our observations we found staff were rarely seen in the lounge.

The four care plans we looked at did not demonstrate that people who lived at the home or their representatives were involved in planning and reviewing care. There was no record of either people who lived at the home or their relatives' involvement in care records. We asked relatives if they were involved and they told us they were not. The registered manager failed to ensure care planning was consistently collaborative and followed people's preferences.

The registered manager acknowledged this and accepted that this was not satisfactory.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to provide person-centred care that met people's needs and reflected their preferences.

We spoke with the registered manager about how they developed care plans when people were admitted to the home. She told us care plans and risk assessments were completed soon after admission and they were reviewed and updated by senior staff. We looked at four peoples care records and other associated documentation. These were not always accurate and up-to-date even when they were recently reviewed. Other care records had important information missing. We looked at one person's care plan that stated they

often had stomach discomfort. We saw they had no care plan or pain tool to inform staff of how they could help to reduce the pain and if necessary when to give pain relief.

Health issues were not always followed up where a person was in pain or ill. One person had recently fractured their shoulder but their care plan and risk assessments had not been updated. Information in care plans for a person with diabetes said in one area they were diet controlled and another area tablet controlled. Two people's daily reports showed they were regularly incontinent, but their care plans indicated they were continent.

The daily records were not informative and did not always reflect what had happened in the day. One person's records indicated they had eaten a fair diet. Yet the inspector had observed them refusing lunch and this was then taken away. Another person had received an unexplained injury. Although an accident record was completed this was not recorded in their daily report or communicated to all staff. A record in the person's daily report showed staff were unaware of the injury as they recorded bruising cause unknown.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person.

The home had a complaints procedure which was made available to people they supported and their relatives. We saw there was one ongoing complaint, which was being investigated. There had been no other recent complaints. The registered manager told us the staff team spoke regularly with people and their relatives. They told us they tried to deal with minor issues before they became a concern or complaint.

We asked people if any complaints were dealt with quickly and appropriately. People who lived at Rosehaven and their relatives told us they were aware of how to make a complaint. They said they had not made any complaints, but felt they would be listened to and concerns would be acted upon. However, one person said they felt they would not be listened to and any complaint would not be dealt with.

We saw there were thank you cards from people who had stayed at Rosehaven and their relatives. These comments included "Thank you for taking me in at a time of need." "Kindness and compassion shown to us all." And "Thank you for looking after me so well."

Inadequate

Is the service well-led?

Our findings

The registered manager had been in place for four years. The majority of the twelve people who lived in the home and relatives we spoke with were positive about the management approach and support. One person told us, "The manager is very kind." A relative said, "The manager is very pleasant and always stops for a chat." Although another relative said they found it difficult to get answers to questions.

We did not find the home well led. The registered manager did not show all the necessary skills and knowledge to manage effectively. They were not fully aware of their responsibilities as the registered person. They did not ensure that care was safe and that staff were recruited safely or deployed effectively. They did not improve practice where care was poor. They did not have appropriate knowledge in relation to the Mental Capacity Act 2005 and associated DoLS. The registered manager had not always notified CQC about issues that affected the health, safety and welfare of people who lived at the home, which they were required to do. These included serious injuries and safeguarding concerns.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who lived at the home.

The management team had not developed staff to make sure they displayed the right skills and behaviours towards people. Although staff were kind when interacting with people they did not always display good care practice. We did not see the staff team using evidence based practice in making decisions about the care of individual people or learning from best practice in specific areas of care. Neither did we see any areas of care that the management team had identified as areas for improvement.

Although audits were carried out these were limited and not completed consistently. The audits included monitoring the homes environment, care plan records and medicines. Yet the audit systems were not picking up the areas of concern identified during this inspection process. Accidents and critical incidents had not been investigated promptly and appropriate action taken. This left people at risk of injury.

The registered manager told us the views of people who lived at the home were sought informally as well as during infrequent resident's meetings. This was confirmed by talking with staff, relatives and people who lived at the home.

Staff we spoke with told us they felt the manager was supportive and approachable. One member of staff said of the registered manager. "She is brilliant, so supportive and helpful." Another member of staff told us, "I can ask any of the senior staff for help, well any of the team really. We try to pull together." However, one member of staff was less positive about the manager. Staff told us there were resident meetings and staff meetings held to give everyone a chance to air their views.

One person who lived at the home had received an unexplained injury. Although an accident record was completed the daily record did not report anything about this. Records were limited and there was no

investigation into how this occurred. Although there was evidence of an injury the person was not taken to hospital until five days later. The person had received a fractured shoulder. Action had been taken about these incidents, although no notifications regarding the safeguarding or the serious injury were sent to CQC, which the registered manager was required to do.

This was a breach of Regulation 18 care Quality Commission (Registration) Regulations 2009 because the provider had failed to inform CQC of incidents affecting the health, safety and welfare of people who lived at the home.