Rosemount Care Home Ltd

Rosemount Care Home

Inspection report

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Date of inspection visit:
08 March 2016
09 March 2016
10 March 2016

Date of publication:
03 June 2016

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 was carried out over three days on the 8, 9 and 10 March 2016. Our visit on 8 March was unannounced.

We last inspected Rosemount Care Home on 14 September 2015, when we under took a comprehensive inspection, including looking to see if the provider had met the requirement actions made at the previous inspection in April 2015. During the inspection on 14 September 2015, we found further breaches of the regulations in relation to some parts of the building and premise not being safe, appropriate risk assessments not being undertaken, unsafe management of medicines, there were concerns around poor infection control, obtaining consent from people who use the service and a lack of meaningful activities for people. We also found unsafe recruitment processes, staff employed had not received any formal induction when commencing employment, staff were not receiving supervision or appraisals and there were gaps in staff training. Following this inspection we issued ten requirement notices, which the provider had to send us a report detailing what action they were going to take, and made five recommendations. The service was rated inadequate overall, which meant it was placed into 'Special measures.' During this inspection we found limited improvements had been made.

Rosemount Care Home is a care home based in Edgeley, Stockport. The accommodation is arranged over two floors accessed via stairs or a chair stair lift. The communal areas include an open plan lounge and a smaller quiet lounge, both lead into the dining room. There is a garden and patio area to the rear of the property and off road car parking. No en-suite facilities are available.

Rosemount Care Home is registered to provide care and accommodation for up to 17 older people some of whom may also have a diagnosis of dementia. At the time of our inspection there were 10 people living in the home.

The service did not have a registered manager in place. The home had been without a registered manager since November 2014. 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.

At the time of this inspection the provider had purchased the services of a consultant, who had taken up the role of "acting deputy manager," commencing 15 February 2016.

During this inspection we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Eight of which were continued breaches of the regulations and one new breach.

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.

Medicines continued to be managed unsafely although we did see some improvements from the last inspection. We were told one person was currently self-administrating some of their medication. A risk assessment had not been undertaken to ensure the person was safely able to self-administer their own medication in accordance with their own medication policy.

We continued to have concerns in relation to staff supervision and appraisals, because as identified at the last inspection not all staff had received regular, formal one to one supervision and none of the care staff had received an annual appraisal, which meant that staff were not being appropriately guided and supported to fulfil their job role effectively.

From looking at the training matrix (record) and speaking with staff we found there were gaps in staff training. This meant some staff may not be appropriately trained and skilled to meet the needs of the people living at the home.

We saw some evidence that staff had completed induction training. However the homes induction was not robust enough. In one staff file there was no evidence of any induction training and in a further three staff files looked at the induction training dates recorded were before the staff members had commenced employment.

We found there were still concerns regarding the safe recruitment of staff and ensuring suitable staff were employed.

Consent to care had not been appropriately obtained from some people using the service.

We recommend that in order to preserve the dignity of people food is not served in plastic dishes and beakers unless there is an identified need for this.

We found that accurate and complete records were not kept in relation to the care and treatment of some people who used the service.

We found risk assessments were not always in place to help manage and reduce the risks to people's health, safety and welfare.

We saw there were no cleaning schedules in place to demonstrate what cleaning had been undertaken in the communal areas of the home including bathrooms and WC's.

As identified at the last inspection robust systems were not in place to monitor the quality of service people received.

We saw some improvements to the environment for example new carpets and redecoration to the communal lounges and dining room.

We saw and staff told us there were enough members of staff to keep people safe.

Staff we spoke with were able to tell us how they would respond if they had any concerns about the safety of people living at Rosemount care home.

Visitors we spoke to whose relatives used the service told us they thought Rosemount was a safe and caring place to live and they thought people were happy and well looked after.

Relatives spoken with told us they had never made a complaint but told us that they thought any issues raised would be dealt with to their satisfaction.

We saw that activities were provided by the staff on duty which people enjoyed. However we recommended that individual assessments of people's hobbies and interests were undertaken and recorded to ensure that the activities provided were in accordance with people's personal preferences.

We saw staff had good relationships with the people they were caring for.
The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use of enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 always safe.

Suitable arrangements were in place to safeguard people from abuse.

We found that the provider had not done all reasonably practicable to mitigate risk to people.

Shortfalls were found in the medication administration processes, where people who use the service were responsible for administering their own medication under the supervision of staff.

There were no cleaning schedules in place to demonstrate what cleaning had been undertaken in the communal areas of the home including bathrooms and WC's.

Is the service effective?

Inadequate

The service was not always effective

Not all staff had received supervision and no staff members had received an annual appraisal.

There were gaps in the training staff had undertaken.

Consent to care and treatment was not always sought in line with legislation.

People could make choices about their food and drink.

Is the service caring?

Requires Improvement

The service was not always caring

Our observations highlighted that almost all people who used the service sat in the same chair throughout the day.

We were told that the home had provided end of life care although only one member of staff had undertaken current training.

People's relatives told us they thought their loved ones were well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive

A system was in place for receiving, handling and responding to concerns and complaints.

Swift action had not been taken when a person had lost weight.

Activities were provided by staff on duty but they were not necessarily in response to people's individual hobbies or interests.

Is the service well-led?

Inadequate

The service was not well led

At the time of this inspection the manager was not registered with the Care Quality Commission.

We found very limited improvements had been made since our last inspection.

The quality assurances systems in place were not sufficiently robust to identify the issues and concerns we found during our inspection.

Rosemount Care Home

Detailed findings

Background to this inspection

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

This inspection was carried out over three days on the 8, 9 and 10 March 2016. Our visit on 8 March 2016 was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection report about the service and notifications that we had received from the service. We also contacted the local authority commissioners to seek their views about the home. They had currently suspended local authority funded placements to the service and were working with the service to address concerns.

On this occasion, we did not request a Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

During our visit we spoke with the acting manager, the deputy manager, three care workers, a member of domestic staff, the cook, three visiting relatives and four people living at Rosemount Care Home.

We looked around the building and looked in a sample of bedrooms on each floor, all communal areas, toilets and bathrooms,

We examined seven people's care records, medicine administration records, the recruitment, supervision and training records for four staff and records relating to the management of the home such as auditing records.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 14 September 2015, we found a breach in regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to shortfalls found in relation to medication administration.

During our inspection on the 8 March 2016, we looked at what systems were in place for the management of medicines. We saw some improvements been made since the last inspection and that the provider had accessed an independent company to supply the service with policies and procedures. We saw that a medication policy dated 11 September 2015 had been implemented which was in line with current legislation.

We were told that nobody was receiving covert medication. Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medication for example by administering it in food and drink. As a result, the person is unknowingly taking medication.

People we spoke with told us they received their medication on time.

We saw that an up to date staff signature list had been implemented, enabling the service to identify who had administered medicines or made an error.

We saw that records were being maintained of prescribed creams on cream charts, which had body maps to demonstrate where the creams were to be applied and written directions for their use, enabling staff to apply creams appropriately and ensure the comfort of people who use the service.

We checked the systems for the receipt, storage, administration and disposal of medicines in the home. There was a small dedicated treatment room on the ground floor that was used to store and lock away medicines, including controlled drugs. Medication was stored in a locked medication trolley, in a locked treatment room to ensure only authorised people could access them.

We were told that care staff were not allowed to administer medication until they had received training and undertaken a competency assessment and staff spoken with confirmed this. During the inspection we looked at the overall staff training matrix (record) and saw that seven members of care staff had undertaken medication training although one person had undertaken the training in 2012, which meant this training, was out of date. We were told that three of those care staff worked nights.

We found that no excessive stocks of medication were being stored.

We found that appropriate arrangements were in place for the storage of controlled drugs which included the use of a controlled drugs register. On the days of our inspection nobody was having controlled drugs.

The home operated a Monitored Dosage System (MDS). This is a system where the dispensing pharmacist

places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed.

We asked how the home stored and recorded medication that were to be disposed of. We saw that there was a record kept of medication that was waiting to be disposed of. We saw that medication was stored in an open cardboard box in the treatment room while awaiting pick up from the dispensing pharmacy. In line with the National Institute for Health and Care Excellence (NICE) guidance medicines for disposal should be stored securely in a tamper-proof container until they are collected or taken to the pharmacy to ensure they are not tampered with.

There was a system in place for recording the temperature of the medication fridge twice a day to monitor that medication was stored at the correct temperature. However we saw there were gaps in the recording. In February 2016 there were 15 gaps and 12 gaps in January 2016. We found the recording form to be confusing as it stated the acceptable fridge temperature range should be between 2 and 8 degrees but to strive for 5 degrees centigrade. The current temperatures had been recorded between 2 and 5 degrees centigrade but the maximum temperature column for all of January 2016, February 2016 and up to 8 March 2016 had been recorded either 24 or 25 degrees centigrade. In addition we saw a system in place to record the daily medication room temperature twice a day. We saw 30 gaps in the temperature recording from January 2016 to 8 March 2016. This meant there was a risk that medication may not have been stored consistently at the correct temperature which could compromise the stability of the medicines stored.

At the time of our inspection we were told one person was self-administering two of their medications. We looked at the home's medication policy in relation to self-administration and saw this had not been implemented. A full assessment of their ability and mental capacity to self-medicate had not been undertaken and there was no evidence of regular checks of the medication to ensure the medication had been appropriately taken.

Following our inspection in September 2015, we received information from the provider dated 6 November 2015, stating that PRN medication (which means Medicines that are taken 'as needed') is now checked three times a day. We did not see evidence of this during our inspection on 8, 9 and 10 March 2016. We saw that a check sheet had been implemented on the 1 January 2016. But from the 1 January 2016 to 8 March 2016 we saw that the check sheet had only been signed as completed on seven occasions.

We saw a 'medication file check' sheet, which stated 'to be completed by senior/manger every week.' Since the 31 October 2015 to 8 March 2016 we saw five completed sheets. These sheets had not been consistently completed and were not sufficiently robust enough to identify shortfalls in the administration of medication and any action taken as a result. For example on 31 October 2015 to the question 'Is the file neat and tidy' it was unclear, which files had been checked and the comment was 'could be neater' but there was no explanation which parts could be neater and no evidence of what action was taken. On the 7 November 2015 to the question 'Any missing signatures' the comment was '1 x missing signature.' There was no evidence which person or medication this related to and there was no evidence of any action taken.

The above examples demonstrate a continued breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on the 14 September 2015 we found a breach in regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not undertaken appropriate checks to ensure suitable staff were employed. During this inspection we did not find any improvements.

We reviewed four staff personnel files and looked for references for another staff member. We saw in two files that the application forms had not been fully completed, and found in one file there was no proof of identification or address for the person... We saw that email addresses for references were sent to personal email accounts and not company specific email contacts. This meant there was no way of confirming the person completing the reference worked for the organisation the new member of staff had stated they had previously worked for, or that the new member of staff had worked for that organisation. In another file the job offer made was a month before the date on the completed application form. We saw in another staff file that the job offer letter requested a signed copy to be returned to the service by a date that was earlier than the date on the application form.

There were no references for one person employed and only one reference for another person. This meant that appropriate checks were not undertaken to ensure suitable staff were employed.

We saw in one staff file that a Disclosure and Barring Service (DBS) check had been received over a month after the date employment commenced. There was no evidence that the staff had worked under supervision until a clear DBS had been received. The DBS is a national agency that holds information about criminal records. DBS checks aim to help employers make safer recruitment decisions and minimise the risk of unsuitable people being employed to work with vulnerable groups of people.

For one person employed in 2011 there was no evidence that DBS had been applied for. The acting manager said they would be taken off the rota until a clear DBS had been received.

The acting manager told us she had undertaken an audit of the staff files. However the audit had not been robust and had not identified the shortfalls found on inspection.

The above examples demonstrate a continued breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As identified at the last inspection a risk assessment was in place in relation to separate living accommodation for four people on the third floor of the home. The risk assessment dated 5 December 2015, identified that only people who worked for the service and relevant reference and Criminal Records Bureau (CRB), now known as DBS checks, had been carried out were able to reside in the accommodation. This policy contained outdated information because from 1 March 2013 CRB checks were replaced by DBS checks. We were told that two of the tenants no longer worked for the service and we saw that for one person there were no references and for a 2nd person there was only one reference. In addition the DBS for one person, who no longer worked at the home, was dated 2010 and 2012. These breaches of their own risk assessment meant measures to mitigate risk had not been followed, reviewed and updated which had the potential to put people at risk.

We looked at a number of environmental risk assessments in place, for example Exit in hallway leading to cellar, COSHH, Electrical safety, Gas safety, Manual lifting, Office. We saw that these were not dated and there was no evidence that these had been reviewed and remained relevant. We saw the information contained in these was basic and did not sufficiently direct staff on how to manage risks within the environment.

On the first day of our inspection we saw that a new carpet had been fitted in the main lounge area of the service. However we noted that this had not been fitted correctly and there were sections of the carpet that were raised and presented as a trip hazard. We spoke with the acting manager who told us that this had been reported and they were awaiting the company to return to fix the carpet to make it safe. In the

meantime there was no risk assessment in place to show how the service was to ensure people did not trip on the hazard and maintain safety.

During our last inspection we saw some of the corridors in the service did not have light bulbs fitted and were dark. This presented as a risk for people who used the service of slips, trips or falls. During this inspection we found a different corridor where three bedrooms were located was not lit and without natural light. This area was extremely dark and visibility was very poor. We checked the ceiling and found that a light was in place but was not working. This meant that people whose bedrooms were located in this area would be at risk of tripping or falling or becoming disorientated due to such limited visibility. We spoke to the acting manager regarding this who was unaware that the light was not working. They told us they would get this looked at.

People who used the service had Personal Emergency Evacuation Plans (PEEP's) in place. These detailed the level of support the person would require in an emergency situation and meant that in the event of an emergency people should be evacuated effectively.

A fire emergency plan was also available in communal areas to instruct people what to do if they discovered a fire, escape routes and assembly points. Inspection of records showed that an up to date fire risk assessment was in place. Records we looked at showed that monthly checks were completed on fire doors and emergency lighting. Weekly checks were also undertaken of fire extinguishers and fire exits. However we noted that the fire alarm system should be checked on a weekly basis and this was not always being completed weekly. We also found that the fire escape was not externally checked to ensure these were safe and free from hazards and suitable for use in the event of a fire.

During our last inspection we found the service had a fire drill policy in place which stated drills were to be undertaken on a quarterly basis. However, records we looked at confirmed the service was undertaking fire drills on a six monthly basis not a quarterly basis. During this inspection we saw the policy had changed and six monthly fire drills were to take place. Records we looked at showed that one fire drill had taken place since our last inspection. This drill involved four of the seventeen staff employed by the service. This meant that staff who had not been involved in a fire drill may not know how to safely and effectively evacuate people in the event of a fire situation.

At our last inspection we found hazards in the cellar area of the service. We saw the mains electrical installations were in the spare room which also contained a significant amount of old furniture, electrical equipment and paperwork. There was no smoke detector in this room. We found rubbish was being stored under the stairs leading down to the cellar. We checked the laundry and found old equipment; bedding, dust sheets and a pram were being stored in this area. During this inspection we found that work had been carried out in the cellar. All the electrical wiring had been secured and new ceilings had been installed and some of the rubbish had been removed. However we saw that wood was being stored underneath the stairs and the spare room still continued to house old furniture, electrical equipment and paperwork. We also found that the linen cupboard in the downstairs area of the service did not contain a smoke alarm. These issues continued to present as a fire hazard.

We saw that all the gas and electrical equipment had been serviced and checked. This included the electrical installation, gas appliances and portable electric appliances. Since our last inspection windows had been fitted with a suitable device fitted to prevent people who used the service from falling out accidentally.

The service had an emergency contingency policy in place. This detailed people that staff could contact in

an emergency situation such as police, gas and heating engineers, lift engineer, plumbers and electricians. The policy also directed staff on how to respond in situations such as flood, gas leaks and electricity failure.

We looked at the record of accidents file in place within the service. We saw an incident analysis was in place which looked at the number of accidents/injuries that had occurred on a monthly basis. This checked if a person had fallen, if it was in relation to fire or a hospital admission. This would provide the acting manager with an overview of the types of accidents and incidents that had occurred and what action was needed. We also saw that all accident and incidents had been documented and a copy of the accident sheet was kept in the persons care file.

During our last inspection we found water temperature recording charts located in bathrooms that staff were to complete on a daily basis. We found these had not been completed since the 10 September 2015. During this inspection we saw that these recording charts had been removed from some of the bathrooms and it remained the service policy to check the temperature of the water prior to bathing people. We found no evidence that these checks were being completed. This meant people were at risk of being bathed in water that was above recommended maximum temperatures.

We looked in one cupboard and found hazardous substances were being stored in it along with staff coats and a purse which was visible. This cupboard was not locked and was accessible to people who used the service, despite there being a keypad lock fitted to the door. Hazardous substances should be stored safely and where they are not accessible to people who use the service.

During the course of our inspection we saw that Safety Data Sheets in relation to Substances Hazardous to Health had not been obtained from the suppliers of the cleaning materials used in the home, as per the requirements of Control of Substances Hazardous to health (COSHH) Regulations. COSHH legislation requires employers to control substances that are hazardous to health and to ensure safe use, therefore the absence of these has the potential to put people at risk.

We saw that personal protective equipment (PPE) was available throughout the service. We saw that staff members wore aprons and gloves when providing care and support to people who used the service.

During our last inspection we found that some bedrooms had an offensive odour, one room had soiled bed rails, the carpet in one room was badly stained and some bedding was stained. During this inspection we found improvements had been made. We saw that a number of carpets had been replaced, new bedding and curtains had been purchased and the cleaning regime had improved. We also saw that new 'crash mats' which were used for people who were at risk of falling out of bed, had been purchased.

The service had an infection control file in place. This contained a certificate in relation to legionella safety and evidence that the service used an external contractor to remove clinical waste. The service had a number of policies in place in relation to infection control such as, linen, waste management, environmental cleaning, hand hygiene and personal protective equipment. However we noted these were policies that were in place during our last inspection when we found they did not reflect what the service was doing in practice. This remained the same during this inspection and some of the policies had been hand written on, contained out of date information, wording crossed out and had not been dated. This meant there was insufficient, current and appropriate information available to staff members to guide them in their roles.

We asked to see the cleaning schedules in place to evidence that cleaning had taken place. We saw the schedules for peoples bedrooms were basic and were completed using a tick box system and did not describe individual responsibilities for cleaning, therefore did not evidence exactly what cleaning was

required and what cleaning had been undertaken. We saw there were cleaning schedules in place for people's bedrooms but we were told they did not have any for the communal areas including the hall, stairs and landings, the lounge, dining room and the quiet lounge, the bathrooms and WC's. We were told although Stockport Health Protection and Control of Infection Unit undertook audits the service did not undertake any audits or regular checks of cleanliness. We saw that the cleaning schedules were being inappropriately stored in a file alongside key worker notes and hourly checks charts for people. This meant that the service could not demonstrate good infection control and cleaning systems were in place to ensure people received safe and effective care.

The above examples demonstrate a continued breach of Regulation 12 (1) and (2) (a) (b) (d) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found that improvements had been made in the laundry of the service. We saw that all the rubbish and old items had been removed. We saw a new sink unit was in the process of being fitted and when completed would give staff somewhere to wash their hands after dealing with soiled linen.

People we spoke with told us they were happy living at Rosemount Care home and the staff were nice and kind. One person said "The staff are friendly and I have no problems."

All of the visiting relatives spoken with told us they felt confident that their relative was safe and well cared for. One person said, "I don't worry about [their relative] when I am not there." Another person said "I wouldn't want [their relative] living anywhere else she is well looked after here." All people spoken with told us they had never seen anything unsafe or anything of concern.

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. We saw from the training matrix that fourteen out of the seventeen staff employed, which included domestic and catering staff, had undertaken safeguarding adults training. Staff had access to a safeguarding policy, including local authority's multi-agency safeguarding adult's policy which included details of how to make a safeguarding referral and a Whistle Blowing policy. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice.

We saw that there was a record of safeguarding incidents that had been sent to the local authority on a monthly basis. However there was some confusion as to what was a safeguarding incident or a complaint. For example we saw a complaint around the lack of choice of food had been reported as a safeguarding incident rather than recorded as a complaint. In another record we saw that it stated to 'see the notes attached' but there was no evidence of any attached notes.

Care staffing levels in the home consisted of three care staff during the day and two care staff for night duty. The acting manager and deputy worked on a supernumerary basis. We were told the acting deputy manager worked three days a week and the deputy manager worked full time.

We looked at the staffing rotas for a four week period which confirmed that levels of staffing were consistent on a day to day basis and feedback received from staff and visiting relatives confirmed there were sufficient numbers of staff on duty at any one time to provide safe care.

We saw that there was not an identified first aider for each shift. It was discussed with the acting manager that to help reduce the risk to people there should be an identified first aider for each shift in case of an emergency. The acting manager assured us that they would update the staff rota to identify this.

Inadequate

Is the service effective?

Our findings

During our last inspection we found a breach in regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that staff were receiving annual appraisals or ongoing supervision, which meant care as staff had not received all necessary direction and support to carry out their role safely. At this inspection we found that the service was still in breach.

The acting manager told us that at the time of this inspection no staff had received an appraisal and this was confirmed by the staff we spoke with. We were told that since the last inspection seven out of the seventeen staff employed had received a supervision session. We saw evidence that six people had received supervision. However in two of the supervision notes we saw that issues had been raised but there was no evidence of action taken to address the issues raised. This means that people living at Rosemount Care Home were at risk of receiving inappropriate or unsafe care and support because staff had not received on-going support to guide them in their roles and responsibilities.

The above examples demonstrate a continued breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found a breach in regulation 12 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not ensure that the persons providing care or treatment to services users had received formal induction and had the qualification, competence, skills and experience to do so safely. During this inspection we found the service to still be in breach.

Following the last inspection we received information from the provider dated 6 November 2015 stating that new recruits had been enrolled on the Care Certificate and they had improved the personnel records particularly in respect of the documenting of induction training provided. We did not see any evidence of this.

We looked at the personnel files for four staff members employed by the provider between May and November 2015. From April 2015 new health and social care workers should be inducted according to the Care Certificate framework. This replaces the Common Induction Standards and National Minimum Training standards. The acting manager told us that one staff member was currently undertaking the Care Certificate. We did not see any evidence of this. In two of the staff files looked at we saw no evidence of induction being undertaken. In two other staff files we saw evidence of the home's induction being completed; however this was a one sheet, tick box induction. The induction sheet in one file did not include the staff member's name and in the second file it only included a first name and it was not signed by the person completing it.

In one file we saw that the induction was dated over two months following the date the person commenced employment and in the other file the induction date was a month prior to the date employment

commenced. One staff member we spoke with told us they had not had any induction and another member of staff said their induction consisted of reading some policies and procedures and shadowing a member of staff for a couple of days. This meant the provider could not be confident that new staff members providing care had the competence, skills and experience to do so safely.

We looked at the overall training matrix for the staff employed. The first matrix we were given was not up to date. On day two of the inspection we were given an updated copy. We saw there were gaps in staff training. For example out of the thirteen care staff and one bank staff employed, only one member of staff had received training in managing behaviour that challenged, twelve members of staff had not received equality and diversity training, nobody had received person centred care or communication training, five members of care staff had not received pressure area care and one member of staff had undertaken the training in 2012. We saw that only one staff member had undertaken End of Life training and the service had recently provided end of life care.

The domestic member of staff had not received COSHH training and as identified during the last inspection. One cook had not received food hygiene training and the second cook had completed the training in 2012. In addition staff told us they prepared drinks and snacks at the request of people and served meals. We saw ten members of staff, which included the bank member of staff, had not received food hygiene training since 2014. This meant that the registered provider had not ensured staff had the qualifications, competence, skills and experience to meet the needs of people receiving a service and that practices at the home reflected up to date best practice guidelines...

The acting manager showed us a plan for future training but no training had been booked and it was unclear how the training needs of all staff had been identified, as no appraisals had taken place to check and review staffs training needs and to identify areas of development to ensure staff had access to the necessary support and training to carry out their job roles safely and effectively.

The above examples demonstrate a continued breach of regulation 12 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 there 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).

During our last inspection we found a breach of regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 because consent not been obtained from people with the appropriate statutory authority.

The acting manager gave us a list demonstrating that nine DoLS had been submitted to the Local Authority. When we looked at the file where the application information was held we could only see that four applications had been made. One urgent application had been sent on 12 August 2015. An urgent authorisation can never be given without a request for a standard authorisation being made simultaneously.

There was no evidence to demonstrate that a standard application had been applied for, that the application had been authorised, that an extension had been applied for after the seven day "Urgent" period and that the local authority had been contacted regarding the application. This meant that the care given may have been unlawful.

All of the DoLS applications seen had been made between August 2015 and November 2015. There was no evidence of a system in place so the management team could track the applications made. We were told that none of the applications had been authorised.

We saw one of the DoLS application's was applied for in September 2015 yet the MCA assessment had been completed in January 2016. Another DoLS application had been applied for in August 2015 yet the MCA assessment had been undertaken in December 2015. A further application had been made in August 2015 and the MCA had been completed in December 2015. The acting manager was unable to give an explanation for this. This meant that the registered provider had not acted in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 Code of Practice and people may have had their liberty unlawfully restricted.

During this inspection we looked at how decisions were made for those people who had been assessed as lacking capacity to make decisions for themselves, ensuring this was in the person's 'best interests'. We noted, on the records we looked at, capacity assessments had not been carried out when decisions were being made. This is important as some people may have fluctuating capacity and may be able to make some decisions about their care and support, but need help in other areas.

We looked at one person's care records and found that documentation stated that their relative had enduring power of attorney and they had signed a consent form to agree to the care and treatment for their relative. However, we found that the enduring power of attorney that was in place was for financial and property matters and not for care and welfare. This meant that the relative did not have the statutory authority to give consent on behalf of the person using the service.

In another person's file we looked at we found their relative had also signed to consent to care and treatment without the statutory authority in place.

The above examples demonstrate a continued breach of regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records for one person and found they had lost a total of 10kg since the 11 November 2015. We spoke with the acting manager and senior carer regarding this. They informed us that this person had been referred to a speech and language therapist and they were in the process of referring them to the dietician. However, we noted that the care plan had not been updated to reflect this. Without regular reviews and updates care plans do not direct staff members in their role and place people's health and well-being at risk.

We looked at the care records for one person who was prescribed thickeners in their drinks and required their food to be pureed. We asked to see the fluid recording charts in place for this person and were informed by the acting manager that there was not one in place. This meant there was no record of how often thickener had been added to drinks or what consistency was given. There was also no record of what the person had eaten during the day and how this was given, i.e. pureed to custard consistency.

The above examples demonstrate a breach of Regulation 14 (1) (2) (b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

People we spoke with told us the food was satisfactory. One person said "The food is alright and there is plenty of it." Another person said "The food is OK and you get plenty of drinks."
Other people told us they thought the food was very good and there was plenty of it. One person we spoke with said "The food here is excellent".

As part of our inspection, we carried out an observation over the lunch time period. Lunch looked appetising and was well presented, with good portions. We saw that desserts were served in plastic dishes and drinks were served in plastic beakers. The cook told us the dishes were colour coordinated, pink for the ladies, blue for the men; green for the soft diets and purple were for the staff.

We recommend that in order to preserve the dignity of people food is not served in plastic dishes and beakers unless there is an identified need for this.

We were told that whoever was cooking for the day spoke to people individually to ask what they would like to eat. The cook and staff spoken with confirmed this and we observed this during our inspection. We saw alternatives were available and staff supporting people who required assistance in an unhurried and dignified way.

At our last inspection we saw carpets that were badly stained or threadbare, curtains were hanging off the rails in some bedrooms, furniture throughout the service was worn and tired and re-decoration was required in many areas of the service. During this inspection we found improvements had been made. We saw a number of carpets had been replaced with new ones, curtains had been replaced, there was new bedding on people's beds and some areas had been re-decorated.

During our last inspection we found there was a lack of signage within the home to support people living with dementia to orientate themselves around their surroundings, such as signs to identify where the toilets and bathrooms were. At this inspection we found the service had purchased new signs for bathrooms, toilets, dining room, lounge and for bedrooms. This should help people living with dementia to become more independent in their surroundings.

Care records we looked at showed that the service involved other professionals to meet the healthcare needs of people who used the service such as, GP's, opticians and district nurses.

We were told by the staff spoken with 'handover' meetings took place at the start of each change of shift. In addition to the verbal handover a written handover sheet and a communication book was available for staff to look at.

Requires Improvement

Is the service caring?

Our findings

People told us they thought the staff were nice and their privacy and dignity was respected. Some comments included "I can't complain the carers are wonderful" and I am happy here, the staff are nice."

People told us that they were given choice around how they lived their day to day lives. One person said "I can more or less do what I want." Staff told us that choice was encouraged.

Visiting relatives we spoke with told us they felt confident about their relative living at Rosemount Care Home. One person said "I like this care home its home from home." Another person said "It has always felt homely here." All of the relatives we spoke with told us they were always kept informed about their relative's needs.

During our last inspection we saw that almost all the people who used the service sat in the same chair all day; including eating all of their meals. Whilst this may have been some people's choice, some people who used the service were diagnosed with dementia and may not have had capacity to make decisions. We made a recommendation in our last report that the service considered best practice guidance in relation to supporting people living with dementia and how best to support them. Again during this inspection we found most people sat in the same chair all day and the dining room was not used. Having defined meal time routines, such as going to a dining table to eat, supports people living with dementia to orientate themselves to the time of day. The service had not considered our recommendation.

During our inspection we heard staff speak to people in a friendly and kind manner.

There was a relaxed, friendly atmosphere in the home and staff we spoke with told us they enjoyed working at Rosemount Care Home. One staff member said "The care here is very good; we have good relationships with people." Another staff member told us that all staff respect people's privacy and dignity for example knocking on doors and waiting for a reply before entering the room and taking people to their bedroom when being visited by a health care professional.

Staff told us that people were encouraged to be independent. One person living at Rosemount Care Home told us they were a very independent person and the staff encouraged it.

We saw visitors come and go freely during the course of our inspection and visitors told us they could visit whenever they wanted and staff made them feel welcome.

When asked the acting manager said that although advocacy contact details were not on display they would be available on request and we saw that these details were included in the statement of purpose. Such a service supports a person who may need help in making decisions about important aspects of their life and to support them in making sure their individual rights are upheld.

We were told that the service had recently supported somebody through the end of life care and feedback

given to us from a relative was positive. However as already identified in this report we saw that only one member of staff had recently undertaken End of Life training. This meant that not all staff were appropriately trained to provide this care.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we made a recommendation that the service considered implementing care plans that that were designed to meet the needs of people who used the service.

At this inspection we looked at the care plans for four people who used the service. The acting manager told us they were in the process of changing the format of the care plans and updating them. They told us they had completed two new files with the new care plans. We looked at the two new care records and two of the original ones.

Whilst the new care plans were more structured than the previous ones, we found these required further detailed information in order to direct staff members on how to provide care and support for people. We spoke with the acting manager regarding this who told us; "They are the bones of the care plan at the minute and I have to put more meat on them." This meant that people were at risk of not receiving care that had been planned to meet all of their individual needs.

We noted that one person had not had a bath for two months and had been receiving washes. We spoke with the acting manager regarding this, who told us this person often refused to have a bath. However we could see no evidence that the service had considered other ways of encouraging the person to have a bath or evidence to suggest they had refused a bath. This meant that there was not an accurate record of the decisions made in relation to care and care plans did not actively promote person centred care.

We saw some of the terminology used in the new care plans was derogatory such as 'wanders', suggesting that people had no purpose in what they were doing or where they were going. This does not promote respectful attitudes amongst staff members; care plans should be designed to support them in their roles. We spoke with the acting manager regarding this who told us they would address this.

One person's care records we looked at identified that they were at risk of developing pressure ulcers. Care plans stated this person had to have positional changes every two hours and their 'heel boots' (these are padded boots to protect the heels from pressure ulcers) had to be removed every eight hours for pressure relief; staff were to document when this had been completed. We asked to see the recording sheets for positional changes and for the 'heel boots'. We looked at the positional changes recording sheets between the 22 February 2016 and 7 March 2016. We found only two of these had been completed in full to show that positional changes were undertaken every two hours. One sheet dated 4 March 2016 showed a positional change had only occurred once in a 24 hour period. The recording of 'heel boots' relief was not completed on a formal chart but on a blank piece of paper. Inspection of these found that staff did not record when 'heel boots' had been removed and how long for. Most entries stated "heel boots ok." We spoke with the deputy manager regarding this who informed us that positional changes did occur every two hours and 'heel boots' were removed every eight hours and that this was a recording issue. A senior carer we spoke with told us they felt that due to the paperwork being moved out of people's bedrooms, staff were forgetting to complete it when they had undertaken the task.

The above examples demonstrate a continued breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we recommended that the service considers current best practice guidance on providing people with stimulation throughout the day, particularly for those people living with dementia.

Staff told us that they provided activities on a daily basis. During the course of our inspection we saw people enjoying games where a staff member was throwing a ball, playing a card game and hosting a quiz. We also saw that one person was accompanied to go for a pub lunch. We saw a record of activities that had been undertaken included music, watching a film, singing and dancing and board games. When we discussed the activities with the acting manager they confirmed that although activities and stimulation was provided on a daily basis there was no evidence that they directly related to people's individual hobbies, interest or preferences.

We recommended that individual assessments of people's hobbies and interests were undertaken and recorded to ensure that the activities provided were in accordance with people's personal preferences.

The acting manager told us and visiting relatives confirmed that people had their needs assessed before they moved into the home. All the information gathered helped to ensure the home could meet all of the individual assessed needs of the person. The acting manager said if it was appropriate and the person was able they would be invited to visit the home and perhaps have lunch and meet the staff and other people living at the home before they made a decision about moving in.

During our inspection we reviewed the policy in relation to complaints, which was on display in the main entrance of the service and on the back of people's bedroom doors.

All the visiting relatives we spoke with told us they had no complaints. One person told us "I have never made a complaint because generally I am happy." Another relative said "I have never needed to make a complaint."

We looked at the compliant file and saw that since the last inspection two complaints had been made. One complaint was from a relative and the other was from a person living at Rosemount Care Home. We saw that appropriate action had been taken. However we did see a staff member's supervision record had inappropriately been filed in the complaint file, which meant the information relating to this staff member had not been kept securely. This was removed once it was brought to the attention of the acting manager.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service did not have a registered manager in post. A registered manager had not been in post since 20 November 2014.

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

There was an acting manager in place who had taken up the post on 15 February 2016. The management team for the service consisted of the acting manager and a deputy manager.

The acting manager and the deputy manager were on duty on the three days of our inspection.

During our last inspection we found a breach in regulation 17 (1) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to establish and operate effective systems to assess, monitor and improve the quality of service, mitigating the risks relating to the health, safety and welfare of people who used the service not effectively asses and monitor all aspects of the quality of the service. At this inspection we found that the service was still in breach.

Following the last inspection we received information from the provider dated 6 November 2015 stating the manager will review these audits and the provider will also review these regularly to ensure they are effective at improving and maintaining standards and that any issues identified are dealt with. The provider also advised us that they had also added and changed some audits and checks to improve the system. We did not see any evidence to support this.

We saw there were relative feedback forms in the main entrance for people to access and there was a suggestion box if people wanted to leave comments. We looked at the returned feedback forms and saw that responses to these surveys were in the main positive. Comments included, "There seem to be enough staff on duty whenever I have visited", "Staff are kind and respectful towards residents", "Very caring", "They interact well with residents and are caring and interested in them."

We were told by the acting manager there was no formal system for distributing and obtaining feedback for people living at Rosemount Care Home, their visitors, visiting professionals or staff. Returned feedback forms were looked at individually but information was not collated or reviewed collectively and no action plan was developed as a result of this. This meant there was a lost opportunity to improve the service based on the findings of the surveys.

We saw that the service had a copy of the outdated previous regulations and the current regulations could not be located until day three of the inspection.

We saw an information booklet and a service user guide was available for people included the aims and objectives of the home, information regarding the facilities and accommodation available.

We were given a copy of the statement of purpose. However we saw that it included details of the previous manager and incorrectly referred to them as the registered manager. It stated that a list of current staff and their qualifications were on display in the home. We did not see any evidence of this. It stated that the manager worked 40 hours a week and yet the acting manager told us they only worked three days a week.

The statement of purpose stated that new carers completed the Care Certificate within 12 weeks of employment and complete a Level 2 Diploma within 2 years of appointment. We did not see any evidence to support this. There was an organisation flow chart for the service but it did not include any names. This meant that people were given incorrect information about the service provided.

Despite information from the provider stating improvements had been made to the services auditing processes and regular checks being made by the manager and provider. The management team were unaware of any of the issues identified and brought to their attention during the inspection.

We saw staff supervision notes stored in the complaint file and cleaning schedules stored with the key worker notes. Cleaning materials were being used without relevant COSHH information and the management team were unaware of any of these issues until it was identified as part of the inspection.

We looked at the quality audit system in place within the service. We saw audits were undertaken in relation to medicines, bed rails, mattress audits, wheelchair and shower check records and care plans. However we saw that the mattress, wheelchair, shower and bed rail audits were last undertaken in December 2015 and the wheelchair and shower check records' did not include any record of shower checks.

The 'medication file check' had not been consistently undertaken, the paperwork stated to be completed by senior/manager every week and we saw it had been undertaken once in October 2015, twice in November 2015, once in January 2016 and once in February 2016. This meant that systems and processes to assess monitor and mitigate the risks relating to the health, safety and welfare of people had not been operated effectively.

We asked to see the medication audit and were given one audit dated January 2016. We were told that it had not been undertaken for February 2016 and it was not sufficiently robust to demonstrate a detailed audit process. For example it was not clear how often the audit was to be undertaken, which MAR's had been audited, the box for 'any missing signatures,' up to date British National Formulary (BNF) in place and controlled drug administration had not been completed. BNF Publications are published jointly by the British Medical Association and the Royal Pharmaceutical Society. They are independent resources for staff to access and reflect current best practice as well as legal and professional guidelines relating to the uses of medicines. It was not clear which hand written entries the audit was referring to or which stock had been carried forward. The exact date of the audit had been undertaken was not clear, apart from January 2016 and there was no signature to demonstrate who had undertaken the audit.

We saw the care plan audit documentation stated three to be undertaken weekly. We saw none had been undertaken for October 2015, one in November 2015, and none had been undertaken for December 2015, January and February 2016.

During our last inspection we found that the policies and procedures in place within the service did not provide staff with access to up to date information that reflected best practice guidance to support them in

their roles. Policies were not dated and they contained out of date information.

During this inspection we were told that the service had purchased policies and procedure from an independent company and that they required personalising to Rosemount Care Home. The acting manager said that to her knowledge none of the policies and procedures had been reviewed and personalised and they had not yet been fully implemented. We looked at a number of policies and procedures in place including Infection control, Uniforms, Personal protective equipment (PPE), Legionnaires, Health and Safety and Fire Safety. We found none of the policies we looked at were dated; this meant it was not clear when a review was due or if it had been reviewed. Some of these policies contained incorrect information and did not reflect what the service was doing in practice. They also contained hand written notes or typing had been scribbled out so that it was unreadable. This also meant that staff did not have access to up to date information that reflected best practice guidance to support them in their roles.

The above examples demonstrate a continued breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to staff meetings and saw they had been held in October and twice in November 2015. We were told that a meeting had been held in January 2016 but minutes were not available for that meeting.

We saw that meetings for service users and relatives had been held in August 2015 and December 2105. The deputy manager told us that additional meetings had been held but there was no evidence to support this.

The acting manager and the deputy manager acknowledged that significant improvements had not been made since the last inspection.