Barchester Healthcare Homes Limited

Rothsay Grange

Inspection report

Weyhill Road
Weyhill
Andover
Hampshire
SP11 0PN

Tel: 01264772898
Website: www.barchester.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We previously inspected Rothsay Grange on 9 and 13 April 2015 where we identified three breaches of the Health and Social Care Act 2008. We found people had not been protected from the risks of inappropriate care and support, because the provider's recruitment procedures did not effectively ensure applicants were of good character. People were at risk of receiving inappropriate care, because the provider had not deployed sufficient numbers of staff to meet people's needs. We also found people were not supported through the operation of effective systems and processes to assess, monitor and mitigate risks to their health and welfare.

Rothsay Grange provides accommodation and support for up to 60 people who may require nursing and dementia care. At the time of our inspection 49 people were using the service. The home consisted of three floors. The middle floor, known as Memory Lane, cared for people living with dementia. The ground floor accommodated people with personal care needs. The top floor accommodated people requiring re-ablement and respite care, some of whom had long term care needs.

At this inspection we returned to assess whether the provider had made the necessary improvements from our last inspection and to check they met our requirements. We also inspected Rothsay Grange at this time because we had received a number of concerns from relatives and healthcare professionals. They told us people were not receiving the appropriate end of life care and said staff were still not appropriately deployed throughout the home. They told us people were not being supported to look after their skin and said risk assessments and care plans did not always provide staff with robust guidance. We were told of concerns that the leadership in the home was not effective and we were told medicines were not being managed safely or administered at the times people needed them. We were also advised care plans were not in place to assist people who were in pain.

Although some improvements had been made in respect of recruitment and quality assurance, the provider had failed to meet the requirements issued at the last inspection. In addition we identified significant concerns relating to the care and support people received.

The provider did not have sufficient numbers of suitably skilled, qualified and experienced staff deployed at all times to meet people's care and support needs Staff consistently told us they found it difficult to meet people's needs and relatives told us they felt staffing levels were unsafe.

Robust recruitment procedures were not always fully applied.

Arrangements for the management of people's medicines were not always safe.

Safeguarding concerns were not always reported appropriately to the local authority or to CQC. People told us complaints were not always taken seriously or appropriately investigated.

Communicating risk relating to particular conditions and behaviours that challenged others were not always shared effectively. Staff were not consistently provided with good guidance on how to respond to people's needs.

The provider failed to ensure people's freedoms were not unlawfully restricted and documentation did not consistently reflect the requirements of the Mental Capacity Act 2005.

Staff at all levels did not consistently receive appropriate support, supervision or competency assessment.

Staff had not always completed training relevant to their role.

People who were at risk of dehydration or malnutrition were not always monitored effectively. Food and fluid intake records were often incomplete.

Assessments and guidance were not in place to help people manage their pain. It was unclear how staff assessed when people were in pain.

People who were ar risk of skin damage were not always supported properly and investigations into why skin damage occurred were not consistently conducted. There was no evidence of action taken to reduce the chance of skin damage happening again.

People's mental health needs were not always met. There was no guidance for staff on how to support people's mental health needs.

The emotional needs of people who received end of life care were not always assessed and documented.

Actions identified through internal quality assurance audits were not consistently followed up which resulted in people receiving unsafe care.

Leadership lacked consistency and staff told us constant change created confusion in communication and management of the home

Relatives, healthcare professionals and people consistently told us staff at all levels were caring and provided the best service they could.

Documentation detailed information about people's likes, dislikes, hobbies and interests. Records also provided detail about people's past including previous jobs, their religious views and different countries they visited.

People were supported with dignity and patience during meal times. Staff were accommodating, understanding and respectful when they helped people with their food and drinks.

During the inspection visit the provider responded positively and took action quickly when we shared our concerns.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We issued a warning notice in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

You can see what action we told the provider to take at the back of this report.

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. The provider did not have sufficient numbers of suitably skilled, qualified and experienced staff deployed at all times.

The provider did not consistently ensure safe recruitment procedures were applied.

People did not always receive their medicines at the times they needed it and robust arrangements were not in place to mitigate risk.

Is the service effective?

Requires Improvement

The service was not effective. The provider did not consistently comply with the requirements of the Mental Capacity Act 2005.

Staff did not consistently receive effective support, supervision and appraisal.

People who required healthcare including those who were at risk of malnutrition or dehydration were not monitored effectively. People were supported with dignity during meal times and staff displayed compassion and respect.

Is the service caring?

Good

The service was caring. Relatives, healthcare professionals and people consistently told us people were treated with dignity and respect.

Staff demonstrated good values and interacted with people in a kind manner.

Care plans provided good detail about people's personal interests, hobbies and life history.

Is the service responsive?

Inadequate

The service was not responsive. People's care needs including pain management, end of life care, mental health needs and skin care were not always met.

Complaints were not always taken seriously or acted upon.

Relatives and healthcare professionals consistently told us they had concerns about the care provided at Rothsay Grange.

Is the service well-led?

Requires Improvement

The service was not well-led. Actions identified through internal quality assurance systems were not always followed up.

Leadership within Rothsay Grange lacked consistency with staff telling us they were frustrated with constant changes in management and poor communication.

The provider was responsive to concerns we raised and took action during and after our inspection visit.

Rothsay Grange

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 18 and 19 July 2016 and was unannounced.

The inspection team consisted of three inspectors, a specialist nurse with experience in providing nursing care, a specialist GP with experience in pain management and end of life care and an expert by experience with experience in caring for older people living with dementia. A Pharmacist inspector was also part of the team.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We also received and reviewed information from the local authority.

During our visit we spoke with the appointed manager, the regional director, the director of regulation, the HR and recruitment manager, the deputy manager, three registered nurses, a clinical support nurse, 10 care workers, the chef, an activities coordinator, 19 people using the service, 11 relatives and four external healthcare professionals.

We pathway tracked six people. This is when we follow a person's experience through the service and get their views on the care they receive. This allows us to gather and evaluate detailed information about the quality of care. We looked at staff duty rosters; incident records; safeguarding records and complaints. We also looked at staff recruitment files; staff training records; quality assurance records and checked the provider's supervision and appraisal processes. We looked at the provider's quality assurance audits and checked their policies and procedures relating to safeguarding, The Mental Capacity Act 2005 and checked whether people were unlawfully restricted.

We last inspected the home on 9 and 13 April 2015 where we identified three breaches of the Health and

Social Care Act 2008.

Inadequate

Is the service safe?

Our findings

Staff were not appropriately deployed. Staff, relatives and healthcare professionals consistently told us there were insufficient staff to meet people's needs and keep them safe. The appointed manager and the regional director told us they used a staffing tool to assess the dependency needs of each person and to determine the number of staff required and told us they felt sufficient staff were in place. We did not find this to be the case.

On the ground floor there was one nurse and four care staff to care for 18 people. Eight people always needed two to one support with one person having one to one support between 8am and 4pm which was an addition to the staffing numbers. The memory Lane floor provided one nurse and five care staff to care for 10 people who were elderly frail. Six people on this floor regularly needed two to support. A member of staff told us two staff on each unit and one in the dining room was needed. They told us the floor occasionally ran on four care staff which was not adequate. The top floor provided one nurse and three care staff to support 11 people. Five of those people regularly needed two staff to support them. We did not find these staff to be sufficiently deployed at all times to consistently meet people's needs.

A relative of a person said: "There is not enough staff. There are two staff on nights and it takes 2 staff to do the hoists, therefore no one is available to answer call bells and ensure everyone else is safe". A member of staff said: "We are staff down because we also need someone in the dining room because of high fall risk and challenging behaviours, I can't do it all". One person said: "I press the call button and have to wait on occasions for more than 10 minutes" and "There is a big drift towards the use of agency staff". A relative said: "I know the call bell can take up to 15 minutes before a response is made when they are busy and this is obviously a problem". One person's care plan dated six July 2016 stated: "Enjoys both regular baths and showers" and "2 members of staff to be present during all transfers to the bath or shower". We reviewed the person's "Progress and Evaluation Record" from 24 June 2016 to 19 July 2016 and found the person had only had one shower on fourth of July 2016 between those dates. A member of staff told us the high number of agency staff currently employed meant they had to spend additional time explaining each person's care needs which reduced the time they had to provide care. When we asked a regular member of staff to tell us when the person last had a bath or a shower they said: "I honestly don't know the last time he had a bath or a shower" and "We are under pressure because we don't have enough staff which is why we do a strip wash". We observed one person call out for help to use the toilet whilst sitting in the dining area. A member of staff appeared after the person had waited alone for 12 minutes. When the member of staff returned the person said: "I am desperate I shall be wet through". The member of staff apologised to the person and told them they were busy attending to another person. We then saw the staff member support the person to go to the toilet.

A permanent member of staff told us they didn't have confidence in some agency staff and said: "I feel I need to keep an eye on them all the time". Another member of staff said: "I love working with the residents but there is so much to do I often wish there was more time for each one". A healthcare professional said: "When we visit there is sometimes not enough staff around that can help us with people and sometimes they do not know them".

This was a repeated breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as sufficient numbers must be deployed to meet people's assessed needs.

The provider acknowledged the need to recruit additional staff and told us a recruitment drive was taking place. We were advised nursing and care staff would be block booked from agencies to help drive consistency of care and familiarisation for people until permanent staff had been employed. During our inspection visit we observed one registered nurse and five care workers taking part in their induction. We also found a deputy manager had been employed to support nursing staff.

Robust recruitment checks were not always applied. For example a quality audit dated 13 June 2016 stated "3 files checked-all very good with no gaps and references followed through robustly". However at this inspection we found staff were not being thoroughly checked before they provided care. For example, a new member of staff signed the providers "Working under POVA First Policy, Restrictions on Work Activities" record. Working conditions included: "At no time must a new recruit act alone in providing personal care to a resident", "The supervising member of staff must be clearly identified on the rota" and "If the new recruit is asked to provide single care they MUST politely refuse and inform a senior member of the homes staff". Despite having this agreement in place the staff rota did not detail who the supervising member of staff was. A member of staff said: "(Staff member) had a week's shadowing with us but now works as part of the team and delivers personal care without being supervised". A staff rota showed the member of staff concerned had worked in the home eight times from 28 June 2016 to 17 July 2016. When we raised this with management the acting manager and the regional manager took immediate action by removing the member of staff from the rota and told us they were in the process of conducting an ISA check.

This was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements for assessing and communicating risk were not effective. After we observed behaviours that challenged in the dining area we asked two members of staff how they supported people living with dementia to keep them and others safe. One member of staff said: "We know our residents really well and we get handover every day but if we need to know anything we can ask the nurses or the manager". Another member of staff said: "We all have training in dementia and we get to look at the care plans from time to time but we get handover which gives us the information we need". The Handover record did not include guidance for staff about how they should support people with mental health needs or particular behaviours. Dementia comes in many different forms and its progression is unique to each person. Some types of dementia have special characteristics which means if people's records include guidance related to behaviours and risks then staff are more able to be prepared for the range and type of behaviour a person may exhibit. In-depth care plans relating to people's changing physical, mental and emotional needs were not always in place.

Medicines were not ordered in a timely way and not reviewed to ensure people's safety. On the middle floor of the home, eight people's records showed one medicine had been unavailable for them for one or two days in the previous four weeks. This meant they had not been able to have their medicines as prescribed, which could have harmed their health. On the ground floor, we saw that some items crossed off the previous month's record sheets were still on the new records started on the day of the inspection. There was no indication for staff to show whether people still needed these medicines. We looked at the records for one person whose medicines were given by a special tube instead of being swallowed. Staff had agreed the method of administration with the person's doctor. However, there was no record of a review since 30 June 2014 and during that time; some of the medicines had changed. This could increase the possibility of staff giving the person their medicines using an unsafe method.

This was a breach of Regulation 12 (1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)

We saw the nurse on both the ground and middle floors gave some people their morning medicines. Staff followed a safe and respectful method. One nurse had not worked at the home before and another had only worked on the floor for one day previously. This meant they did not know the people they were looking after and took longer to give people their medicines; some people did not receive their morning medicines until 11:30. One person told us that their medicines were always available for them but they did not always receive them at the time they expected. Two people were prescribed medicines, which needed to be given at particular times of day. The nurses were aware of this and made sure they gave these medicines at the correct times.

Each person's medicines administration record had a sheet with a photograph of the person and information about any allergies. Records showed that when medicines were available staff administered them as prescribed. We checked four medicines administered for one person and saw these confirmed the records staff had made.

Some people were prescribed medicines to be given 'when required' such as those to treat pain or anxiety. Additional information was available to staff to help them give these medicines in a safe and effective way. Staff told us they were updating these to make sure they all contained useful information. We saw records for four people prescribed a medicine that required regular blood tests to check the correct dose. Staff kept the results of these tests with the people's medicines administration records, so staff were able to check they were giving the correct dose.

Some people were prescribed creams and ointments. These were kept in people's bedrooms and applied by care staff when they provided personal care. We looked at the creams and records in three people's rooms. Staff had guidance in the form of body maps about where the cream needed to be applied and these had been applied in accordance with the person's prescription. Medicines were stored safely and securely. Suitable medicines storage areas were available on each floor of the home. Each floor had a medicines refrigerator. Staff monitored the refrigerator and room temperatures daily. Records showed these were safe for storing medicines. Suitable arrangements were in place for medicines, which needed additional security. Records for these medicines were checked regularly and showed staff looked after them safely.

The service was not following policies and procedures to protect people from avoidable harm. Safeguarding concerns had not always been referred to local authority when they should have been. CQC were similarly not notified. For example, an incident record dated 27 May 2016 described how one person had not been given the appropriate medicines for a period of three days. Another incident record dated 21 May 2016 described unexplained bruising on someone's nose. Other incident records dated 27 April 2016 and 20 April 2016 referred to skin damage and possible neglect, both of which were not referred to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Requires Improvement

Is the service effective?

Our findings

Staff had not received appropriate support, supervision and training. A member of staff told us they did not have any regular competency checks with regards to administering medication and said they were not observed apart from the very first time they worked at Rothsay Grange. An internal quality audit dated 23 June 2016 asked "Are staff supervision sessions planned 6 times per year for all staff? Have all staff had an appraisal in the past year?" The record said supervisions achieved were at 22%. Six out of 10 care workers told us they could not remember that last one to one supervision they had with their manager and said supervisions and competency checks were not taking place as much as six times per year. A member of staff said: "I think there are group supervisions starting and there are handovers but actual one to one time is pretty impossible because of our staffing issue".

This was a breach of Regulation 18 (1)(2)(a) Staffing.

Some people who are living with dementia are unable to express their views effectively and may need support to make decisions. 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 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. Where people did not have the capacity to consent to care a mental capacity assessment had been carried out with the support of relatives and healthcare professionals. DoLS are put in place to protect people's liberty where the service may need to restrict people's movement both in and outside of the home.

Staff did not always apply the requirements of the MCA. The appointed manager told us out of the 49 people living at Rothsay Grange two people were subject to DoLS, 17 people had been referred to the local authority for assessment with 16 people were yet to be referred. Staff were not knowledgeable about the requirements of the MCA and decisions made in people's best interest were not always appropriately assessed. For example, documentation did not consistently show the implementation of bed rails was appropriately assessed and documented. Choices made in people's best interest were not decision specific and did not detail all information required by the MCA, such as the least restrictive option.

This is a breach of Regulation 11 (1) Need for consent.

The appointed manager acknowledged improvements were required to ensure people's freedoms were not unlawfully restricted. They sent us an email telling us of their intention to refer the relevant people to the local authority for assessment.

People who were at risk of malnutrition or dehydration were not always monitored effectively. A "Nutrition & Hydration Audit January and February 2016" dated 18 February 2016 found fluid intake was not always appropriately recorded. The appointed manager said: "We have started checking people's records everyday". We observed people being encouraged to drink fluids throughout our inspection visit. A relative said: "It is pretty hot and I have seen staff going around asking people and visitors if they want a drink". One relative told us their family member was on a pureed diet which was working well. The relative had experienced problems getting pureed or soft food in the past so they were delighted that the home accommodated this without any problems.

People were supported to make choices about what they had to eat. We observed the chef approach people with a choice of their meal. They had a meal in each hand and offered them both so that people could choose which one they wanted at that time. One person rejected both meals so the chef offered them part of a meal or anything else they felt like eating at the time. They were gentle in their approach and clearly had a good rapport with people and understanding of their needs. This meant that even though most people had cognitive impairment such as dementia they could make a decision based on visual information. Verbal information such as "would you like cottage pie or fish" can be difficult for people with cognitive impairment to understand because it requires a degree of abstract thought. Visual cues are much easier for people to understand for a prolonged period. The chef was therefore communicating with people in ways that would be the easiest for them to understand

People were supported to access healthcare services. For example, one person had been frequently supported to access the optician and the GP, whilst other people were supported by the chiropodist, the district nurse and other healthcare professionals such as the dentist.

Good

Is the service caring?

Our findings

People, relatives and healthcare professionals were complimentary about the staff. One person said: "These girls are fantastic; they listen to me and sort things out for me. I needed to go to a wedding and they helped me to sort it all out - what to wear and get the taxi to take me and bring me back. It was all organised for me". A relative said: "My (Person) gets nursing care here; the girls upstairs are wonderful and I love them to death. The care here is great" and "I am happy with the care and the quality of care". Another relative said: "I wouldn't berate it at all. Everyone is helpful. The care is great. They even feed me! I am here such a lot that I feel looked after too - I even have my hair cut by the hairdresser! I am happy my relative is here and I cannot fault the place". One person said: "The staff are very caring, definitely. But new staff appear out of the blue all the time! They definitely treat us with dignity and respect - they are very good. For example, there are some difficult patients here but it doesn't reflect in any way on the attitude of the staff here. They always devote their caring attention properly to the people who need it".

Staff had a good understanding of the importance of supporting people as individuals and about how they should act to show they respected people's privacy and dignity. One member of staff told us "This is the resident's home. We treat this as their home because it is, so we have to ask their permission to go into their rooms and we all do". We saw staff knocked on people's doors and waited for a response before entering their bedroom. When they went into a person's room they asked permission from the person before undertaking any tasks such as cleaning or providing any care or support function. This showed the staff respected people's space and their rights to regard their bedrooms as their own and not just part of a workplace. We spoke with two people who had just finished lunch and were enjoying time and banter with a member of the care staff. One person told us - in response to asking them if they were happy at the home - "oh yes! This is the Happy Club!" When I asked them for some examples they replied, "The food is good, and the staff are good. This staff member is wonderful and I love her!"

We observed respectful and caring interactions between staff and people on in all areas of the home. The staff took care to ensure people received the support they requested and went out of their way to spend time with people. Overall staff showed an interest in people as individuals and asked their opinions about events in the news and other topical issues. They also asked them about important events in their lives and seemed genuinely interested in people's responses. When staff were available they were quick to respond to people's requests and the staff we observed had a gentle and pleasant manner.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that reflected their needs. For example, a record dated 16 April 2016 documented one person had skin damage on their right ankle, their left heel and a grade 2 pressure ulcer on their sacrum. The record stated the grade 2 pressure ulcer was due to moisture. Moisture damage occurs when bodily fluids come into contact with skin for a prolonged period. It is often the basis for further skin breakdown. The person's mobility care plan dated 18 January 2016 stated they should be moved every two to three hours. However the recordings documented in the person's repositioning chart did not reflect the needs detailed in the person's care plan. For example, the delivery of repositioning care was not documented for a period of 13.5 hours on the 10 July 2016, for eight hours on 14 July 2016, for three and a half hours on 15 Jul 2016 and for six hours on 17 Jul 2016. We could not be assured this person received the appropriate care as staff were unable to tell us if the repositioning had taken place. Records showed one case of further skin deterioration had been referred to the local authority for investigation. An internal quality audit dated 28 April 2016 stated: "Turn charts had no evidence of which side resident had been turned to evidence turning. Care plan documentation is very inconsistent". The provider's policy of conducting a root case analysis to investigate skin damage was not consistently followed. For example, a skin care record dated 20 May 2016 stated five cases of unexplained bruising for one person who was receiving end of life care. There were no associated records presented to us to demonstrate the cause of these bruises had been appropriately investigated. We could not be assured that staff were responding appropriately to meet people's needs.

Staff were not consistently responsive to people's end of life needs. One person's 'Hopes and Concerns for the Future' care plan dated 7 March 2016 stated "(Person) is very aware of their illness. She is not afraid to die but is afraid about how she will die". The reference to a person being afraid is an identified care need but there was no care plan relating to this. It also indicates a risk of depression which can negatively impact on that person's quality of life. The person's daily records dated 17 July 2016 stated "low mood lethargic". We do not know if this was as a consequence of their condition (which had been designated as end of life) or because of fears about their future. For the same person their moving and repositioning care plan dated 18 May 2016 stated "Due to anxiety by (Person) during transfers using the hoist. (Person) will be transferred in a bath chair in her room and transferred by the shortest route and transferred back to bed". There was no guidance for staff about how they should support the person to transfer into the bath chair and there was no record of staff attempts to identify the source of the person's anxiety and support them subsequently.

Robust assessments and detailed pain management plans were not always in place to determine if people had pain and its nature in terms of severity, frequency, type and location. People with cognitive impairment such as dementia are often unable to identify or express pain except through behaviours including resistance to care, agitation, wandering, loss of appetite and withdrawal. If an analgesic has been medically prescribed the person should have a pain assessment at the prescribed administration times to determine if the 'as and when necessary' (prn) dose should be given. In addition, any of the above behaviours should trigger a pain assessment at any time.

One person's pain care plan dated 8 August 2016 stated: "(Person) able to verbalise pain and location.

Usually experiencing pain in abdomen and lower back shoulder and rib cage". The person lived with several significant long term conditions in addition to a malignancy of their colon. They were also registered deaf and blind. These factors would have made the person's ability to express their level of pain difficult. Another person's pain care plan stated "Is not able to express pain". We would therefore expect to find that there were clear guidelines for staff and a standard pain assessment tool in use. Just as pain is subjective its assessment is subjective unless a standardised assessment tool is available and used frequently and regularly by staff. Due to the lack of clear documentation and guidance it was unclear whether staff were able to assess people's pain needs and respond appropriately.

Another person who received end of life care was not supported to manage their pain. The person's care records stated they were agitated, however their documentation did not contain any actions staff should take in the event of possible pain. The person's end of life documentation around assessment and management of symptoms was not always clear to follow and information about the person's condition and health needs were not accurately shared with the GP. A healthcare professional told us the decision to prescribe alternative medicine would have been considered if the provider had shared accurate information about the person's health. They said: "If they (Staff at Rothsay Grange) had told us everything that was going on and explained the symptoms we could have prescribed a different drug to help ease the pain for the person". The absence of a systematic assessment placed this person at risk of being in pain. In addition when we identified people who had skin wounds there was no indication that they were provided with pain control prior to their dressings. being changed. There was a risk people may have been in unnecessary pain.

This was a breach of Regulation 12 (1) and (2)(a)(b)(h) Safe care and treatment.

We discussed wound care and end of life care with the appointed manager, the regional director and showed them the records we were concerned with. They both agreed it was not acceptable and told us work was needed to improve people's level of care. At the end of our inspection visit we told the provider we had significant concerns about how they were providing care to people who were at risk of skin breakdown. A nurse said: "I done an audit since your feedback and I was disgusted at what I found". The provider did take additional action by organising tissue viability training for staff. After the inspection visit we were notified by the local authority that Rothsay Grange had since added a 24 hour advice line to their support network should they need additional guidance in respect of end of life care. The local authority also told us people's end of life documentation was in the process of being updated with support from a near by hospice.

Relatives were not always communicated with effectively. A member of staff told us Rothsay Grange used a reviewing programme called "Resident of the Day" which they followed to check equipment and any maintenance issues were identified and immediately resolved. They also told us people's care plans were reviewed under this initiative. However it was clear relatives were not always familiar with the programme. The minutes of a relatives meeting dated 13 July 2016 stated: "Some relatives present stated that they had never heard of it (Resident of the Day) before and expressed views that this was a shame as it sounded like a really good way of working". A member of staff said: "In theory it's a great idea but because of the high number in agency staff we use and because things keep changing it doesn't always happen".

Relatives and healthcare professionals told us their complaints were not always taken seriously or acted upon. One relative said: "I complained about something a couple of months ago and nobody got back to me, I had to phone several times to get an answer". Healthcare professional's consistently told us communication was poor and despite a number of conversations with staff at Rothsay Grange improvements in respect of communication had not been made. One healthcare professional said: "The communication and the organisation between the management and the staff is very poor, I have raised the

same concerns over and over again and nothing seems to change. I really feel the home needs stability to deal with these problems". We received a number of complaints from whistleblowers who told us their concerns were not always being acted upon. One relative said: "I have had to come to you because the home is getting worse and I am really worried about (Person)." A complaint dated 23 March 2016 detailed concerns about staffing levels and personal items going missing. A second letter from the complainant described their frustrations at their initial complaint not being taken seriously or appropriately investigated.

This is a breach of Regulation 16 (1)(2) Receiving and acting on complaints.

We received mixed feedback from people using the service, their relatives and staff about the activities provided at Rothsay Grange. On the first day of our inspection we observed a singer playing the guitar and entertaining people in the dining area. One person said: "I am really happy when the singer comes in and plays music, we all have a sing song". Some people told us about activities included gardening, arts and crafts, quizzes, baking and visits from pets. Relatives told us people were encouraged to have their hair done, facials and manicures. However four staff told us activities were limited due to the number of staff available. One member of staff said: "There are things that go on here but often people can be left in their room for long period of time without anything to do". Another member of staff said: "Sometimes people are just put in front of the telly in their room and pretty much left until they need something or they ring their bell". Activities need to be based on individual needs and interests and people need to be supported to participate if they wish.

Requires Improvement

Is the service well-led?

Our findings

The provider's website states "Our approach to nursing care is based on the use of personalised care plans. Drawn up with the individuals we support and their families, our care plans will help ensure that each person we look after is treated with respect and that their independence and choices are maximised." And "Barchester Healthcare's highly qualified and attentive staff pride themselves on providing high quality care, which focus on the individual's needs through personalised care plans." We found people did not always experience the level of service detailed in this statement.

Documentation relating to end of life care, skin breakdown, repositioning, food and fluid charts and pain management were not consistently in place or completed in the detail necessary to meet people's needs fully.One person who required regular repositioning did not have a care plan in place to inform staff of the frequency the person needed to be turned. Documents associated with another person who was at risk of dehydration and malnutrition were not always completed. There were significant gaps in relation to their food and fluid intake and their repositioning turning chart was not completed at the required times to show turning had taken place. Records could not consistently demonstrate that action had been taken to meet people's assessed needs.

This is a breach of Regulation 17(2)(c) Good governance

On the first day of our inspection visit we were advised the registered manager had left the organisation. 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. The regional director told us an appointed manager had been put in place to run the home with the support of a deputy manager who was now responsible for monitoring and advising nursing staff in respect of clinical care. After the inspection visit we received an email from the apponited manager telling us it was their intention to apply to become the registered manager.

Relatives, healthcare professionals and people consistently told us they were frustrated at the constant change in leadership within the home since it first opened. A relative said, "The grapevine says these managers don't get the support they need from higher up, but I don't know from whom or what support they mean". One person said "Management? I am confused. Utterly. One of the failures here is communication. I had no idea the manager was contemplating going - let alone gone! I'm told there is a replacement, a "she", she was introduced to some of the residents but I have not even seen her". A relative said: "Sorry to be so critical, but who are these staff who keep appearing? My family member arranged a case review to discuss issues they were concerned about and it was a disaster! When they turned up for the meeting there was no one here to conduct it and no one knew about it". Another relative said: "so many managers here! I can't understand why they keep leaving; is there a problem higher up?" Another relative said: "I was not informed the previous manager was leaving; there seems to be a lack of communication here". A relative told us "One of the issues is the change of managers, when there is no consistency it makes for poor communication and that is a big problem here". A visiting professional told us "Communication

seems to be the issue here, we did not know about the safeguarding meeting until the unit lead told us. This means we may have wanted to attend because some of our clients might be involved. The new unit lead up here though seems really good. She has asked for assessments and that is why I am here today".

The director of regulation, the regional director and the appointed manager acknowledged the service provided at Rothsay Grange was not to the standard they expected. During our inspection and at the end of our visits we met with the management team to share our findings and concerns. We found them to be responsive to our feedback, conducting audits immediately in relation to skin care, making safeguarding referrals to the local authority and organising additional staff training. One member of staff told us they were disappointed to hear such feedback but recognised the need to make improvements. They said: "We have had the local authority in a lot and we are having lots of meetings so I am confident things will improve". Another member of staff said: "We are under a lot of pressure to get things right because we have made a few mistakes and it's not acceptable" and "This is nothing we can't fix, we are already doing loads of audits, having relatives meetings and we have a big recruitment drive on the go".

During the inspection the provider sent us various action plans, quality assurance audits and minutes from relatives meetings. The provider had put arrangements in place to regularly monitor and asses any risks relating to people's care. However it was not always evident who was accountable for driving improvement in particular areas. A member of staff said: "Because we have had so many managers and things change all the time this is why we are in the mess we are in".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider did not ensure incidents of possible abuse were appropriately investigated or reported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider failed to comply with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider did not appropriately investigate and respond to complaints in a reasonable time scale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Records associated with people's care were not consistently accurate and did not always reflect people's care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Treatment of disease, disorder or injury	The provider did not ensure staff employed were consistently subject to a robust recruitment process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff were appropriately deployed all times to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not consistently meet people's needs and care and treatment was not always appropriate or person centred.

The enforcement action we took:

Warning notice Regulation 12