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Rosehill House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 September 2016 and was unannounced. A previous inspection, undertaken in July 2014, found there were no breaches of legal requirements.

Rosehill House Residential Home is situated on the outskirts of Dodworth village, near Barnsley. The home is a detached property within its own grounds, providing accommodation and personal care for up to 23 older people. To the front of the property is a large patio/terrace with garden furniture. Ramps are provided to the main entrance at the side of the building. At the time of the inspection there were 22 people living at the home.

Our records showed there was a registered manager registered for the location. However, the provider told us that this manager had not been at the home some time. He said he would take steps to remove this manager's name from the registration. An acting manager was working at the home. She told us she had been in post approximately ten weeks and had commenced her application to formally register as the manager. Our records confirmed this process was ongoing. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at the home and said the staff treated them well. Staff had received training with regard to safeguarding issues and demonstrated an understanding of potential abuse. They told us they would report any concerns to the acting manager. We found some windows did not have restrictors or devices that met with current Health and Safety Executive guidance for care homes. No risk assessments were in place. There were odours in some rooms, although flooring and furniture was being replaced as part of an on-going programme of refurbishment. The laundry area was not suitable and walls in this area were damp and could not be cleaned effectively.

Suitable recruitment procedures and checks were in place, to ensure staff had the right skills to support people living at the home. People said they felt more staff would be helpful and we observed that at meal times people did not always get consistent support. It was not clear how staffing levels were directly determined by dependency assessments. Medicines were handled safely and effectively and stored securely.

Most people told us they were happy with the standard and range of food and drink provided at the home and could request alternative dishes, if they wished. Kitchen staff had knowledge of specialist dietary requirements. Staff did not always support the social side of the meal time experience.

Staff confirmed they had access to a range of training. The provider had recently appointed an independent training company to support staff across all their homes. Staff told us, and records confirmed that regular supervision took place. The acting manager told us records she had reviewed suggested there had been no recent annual appraisals.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The acting manager had a full record of people who had been subject to a DoLS or for whom a DoLS application had been made. Some reference was made in care plans to taking decisions in people's best interests, although details regarding the least restrictive option were not always clear. We have made a recommendation about this.

People's health and wellbeing was monitored, with regular access to general practitioners and other specialist health or social care staff.

People told us they were happy with the care provided. We observed staff treated people patiently and appropriately. Staff demonstrated an understanding of people's particular needs. People said they were treated with respect and their dignity maintained during the provision of personal care.

Care records were personal and contained good information about people as individuals. Assessments of people's need had been undertaken. Care plans did not always contain sufficient detail for staff to follow or did not reflect advice from health professionals. The acting manager told us she was prioritising reviewing people's care plans. People told us there were some events at the home but activities were limited at the current time. The acting manager told us she had just appointed a new activities co-ordinator, who was awaiting DBS clearance. People and relatives told us they had not made any recent formal complaints and would speak to the acting manager if they had any concerns.

The acting manager told us she carried out regular checks on people's care and the environment of the home. These audits and checks had not always identified the short falls highlighted at the inspection. Staff were positive about the acting manager's approach and said management were approachable and supportive. People living at the home knew who the manager was and said they could speak with her if necessary. A quality audit of people's and relative's views was generally positive about the care. Daily records were generally well kept, although shift handover records were not always personal and used frequent abbreviations.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Safe care and treatment, Staffing, Person centred care and Good governance. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

Some windows in the home did not have restrictors in place that met current guidance from the Health and Safety Executive and risk assessments were not in place. The laundry area for the home could not be cleaned effectively and there were odours in some areas of the home. People told us they felt safe living at the home and staff had undertaken training on safeguarding issues.

People told us they did not always think there were enough staff and we observed people did not get consistent support, particularly at meal times. It was not clear how dependency levels linked to staffing levels. Suitable recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home.

Medicines were managed safely and accidents and incidents were monitored, recorded and reviewed.

Is the service effective?

Requires Improvement

The service was not always effective.

The acting manager was aware of the Mental Capacity Act 2005 (MCA) and applications regarding Deprivation of Liberty Safeguards had been made. Care plans referenced that decisions should be made in people's best interests, but it was not clear the least restrictive option had always been considered.

People told us food and drink at the home was plentiful and the enjoyed the meals. People told us special dietary needs were supported and kitchen staff were aware of people's particular likes and dislikes.

People said staff had the right skills to support them. A range of training had been provided and staff received regular supervision. The acting manager told us there was no record of recent annual appraisals. People had access to health and social care professionals for health assessments and checks.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and were well supported by staff. We observed staff supported people appropriately and recognised their needs, likes and dislikes.

People told us they were involved in their care and relatives said they were kept informed of any changes to people's care or condition. Relatives told us they could visit the home at any time.

Care was provided whilst maintaining people's dignity and respecting their right to privacy. People's diversity and beliefs were respected and supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and relatives told us the home was responsive to their needs. Care plans were in place that reflected people's individual personalities and an assessment of need had taken place. Care plans did not always contain sufficient detail for staff to deliver effective care or did not reflect advice from health professionals.

People and staff told us activities at the home were limited at the moment. The acting manager had recently appointed a new activities co-ordinator. People told us they were able to make choices about their care, including what they ate, whether they wished to remain in their rooms and whether they went out into the community.

People were aware of how to raise complaints or concerns but said they had not made any recent formal complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager, who had not worked at the home for a considerable time was still registered with the provider. An acting manager was in post and commencing the formal registration process. The acting manager undertook checks to ensure people's care and the environment of the home were monitored. However, these checks had not identified the concerns noted at the inspection.

Staff talked positively about the support they received from the acting manager and frequently described her as, "firm but fair."

People and their relatives described the acting manager as approachable and supportive. The provider was keen to maintain the homely nature of the service, whilst also upgrading the building.

Questionnaires had been used to gain people's views and responses were largely positive. Daily records contained good information but shift handover records were not person centred and relied on abbreviations.

Rosehill House Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 6 and 7 September 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

We spoke with three people who used the service, to obtain their views on the care and support they received. We also spoke with two relatives who were visiting the home on the day of our inspection. Additionally, we spoke with the acting manager, deputy manager, a care worker, the cook and the handyman. We also spent some time talking to the provider and the operations director for the provider. We spoke with one health professional who was visiting the home on the day of the inspection. Prior to the inspection we spoke on the telephone with a member of the local authority commissioning team.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; three care records for people who used the service, nine medicine administration records (MARs), three records of staff employed at the home, complaints records, accidents and incident records, minutes of meetings and a range of other quality

audits and management records.

Requires Improvement

Is the service safe?

Our findings

When we arrived at the home spent time walking around the building. We noted windows on the upper floor had internal window restrictors that did not meet current Health and Safety Executive guidance, in that they could be potentially unfastened without the use of a special tool. Two windows also had simple chains fitted held in place with screws. This meant there was a risk to people because appropriate safety systems were not in place. We spoke with the acting manager and provider about this. They told us they were not aware the arrangements did not meet current guidance and would immediately address the matter. The operation director later showed us he had ordered a number of new restrictors, which would be fitted as soon as they arrived.

We viewed the home's laundry area, which was situated in the basement area. The acting manager told us there had been a flood in a room above the area and this had led to water seeping into the area. However, we found there was evidence of long standing damp in the area, with paint flaking off the walls, where damp had penetrated through. We noted that in some areas duvets and pillows were stacked against walls which appeared damp. The walls were rough stone and although painted the surface could not be cleaned effectively. Washed clothes were also hung in this damp atmosphere. We found soiled clothes placed on the floor waiting to be washed, despite a number of baskets being available. The vinyl flooring in this area looked tired and worn in places. This meant the laundry area could not be cleaned effectively and there was a risk of cross infection because soiled clothes were placed on the floor and clean clothes place in a damp environment or against potentially damp walls. We spoke to the operations manager about the laundry area. He said they would immediately look at how the area could be improved.

The home was generally clean and tidy. We did note a number of the divan bases in people's rooms, although covered with valances were quite stained and torn in some places. The acting manager told us that some light pulls in toilets and bathrooms had been replaced to make both easier to see and easier to clean. However, we noted some light pulls were unclean and were of a material that could not be cleaned effectively. We also saw that, whilst toilet areas contained soap, paper towels and had instructions on effective hand washing, some rooms did not have waste bins to dispose of used paper towels. The bin located in the home's kitchen could not be foot operated; meaning staff had to touch the bin when disposing of waste. This meant there was a potential for cross infection because there was either no method of disposing of used towels or bins had to be operated by hand. A number of the surrounds supporting basins in people's bed rooms were cracked or swollen, meaning the areas could not be cleaned properly. We also noted a falls mat; placed at the side of a person's bed at night to help protect them, was being stored immediately adjacent to a toilet in one of the bathrooms. We spoke to the acting manager about this and she told us this should not have happened, although we found it stored in the same way on the second day. She also told us she would arrange for appropriate bins to be provided.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

We noted a number of rooms and areas had unpleasant odours. Whilst people had commodes in their

rooms, these were well cleaned and did not smell. The acting manager told us she felt many of the odours came from the carpets in the rooms and possibly the flooring underneath the carpets. She told us the provider had embarked on a rolling programme to replace flooring in areas where there were concerns. She showed us one of the home's main lounge areas, which was in the process of being refurbished. She explained there had been concerns about the odour in the room so the floor had been re-laid and a new carpet fitted. We saw the room was much improved with no significant odours. A member of the local authority contracts team confirmed there had been issues in this room but the provider had responded and carried out the suggested work. We spoke with the acting manager and the provider's operations manager about the odours around the home. The operations manager told us they were considering both carpet and vinyl replacements around the home. They said they wanted any replacement covering to be practical, but also to maintain the homely feel of the building.

People, relatives and staff all told us they felt additional staff were required at times during the day. One person told us, "They could do with a few more staff. It's at bed time when I notice it most." A relative said, "They could do with more help. It is full on here. They are rushed off their feet" and "They are a bit overworked. They could do with another member of staff." Staff members told us, "There are not enough staff. We are always rushed"; "Another staff member wouldn't go amiss" and "We pull together, but there are not enough staff." We spent time observing meal times at the home. We saw staff were extremely busy trying to serve people meals in the dining room, deliver trays to people who wished to eat in their rooms and support people who needed additional help with meals and drinks. Staff who were supporting people individually were constantly having to get up to offer other people drinks, or encourage them to eat, and were not able to concentrate on supporting the individual they were with. A number of people at the home were living with dementia and so needed significant support and encouragement, otherwise their concentration waned and they forgot they were eating.

We spoke to the acting manager about staffing. She told us there were three care staff on during the day shift and two at night. We spoke to her and the operations manager about meal times. The operation manager told us that normally the activities worker would also be providing care over the meal period. We asked the acting manager about how people's dependency levels influenced staffing levels, particularly related to the number of people living with dementia at the home. The manager told us staffing levels were not determined by her and this was done by the provider centrally. She said she was hoping a number of people would soon be assessed for additional funding, because of their individual needs, and this would allow more staff to be rostered. This meant there was no clear local link between people's daily needs and the level of staffing at the home. We also observed people's individual support was limited at times because staffing levels were not always sufficient to meet needs.

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

People and relatives felt the home was a safe place to live. Comments from people included, "Oh yes, I feel safe here. Lovely staff" and "Yes I feel safe, it's very nice here." A relative told us, "I feel they are safe here. Safer than they were at home on their own." The provider had in place a safeguarding policy. We saw a record had been kept of any safeguarding matters and appropriate action taken when necessary. Staff we spoke with told us they had undertaken safeguarding training and would report any concerns to the acting manager or senior staff. Staff were also aware of the signs they needed to observe for in relation to identifying potential abuse or neglect. This meant that systems were in place to ensure people were protected from potential abuse.

Certificates for equipment and safety issues were in place. For example, we saw copies of Lifting Operations

and Lifting Equipment Regulations (LOLER) certificates for hoists and lifts used at the home, gas safety certificates and five year fixed electrical certificates. The acting manager showed us copies of the home's asbestos survey and legionella testing results, which were clear. There was regular testing of water temperatures for water outlets in bathrooms and showers. We spoke to the handyman at the home who told us fire alarms and smoke detectors were regularly tested and showed us the book he completed with regard to this. He told us he was currently covering another of the provider's locations and this meant he was not always at the home, but tried to keep on top of all the testing and checks, although this could be difficult at times. People's files contained regular risk assessment reviews related to mobility and skin care. Personal evacuation plans (PEEPs) identified the assistance they may need in the event of a fire or other emergency. The acting manager told us she also had a 'grab bag', containing key information that could be picked up immediately if there was an emergency. She said she had not conducted a formal fire drill since she started at the home, but this was one of the matters she was looking to address in the near future.

We looked at personnel files for staff currently employed at the home. We saw an appropriate recruitment process had been followed, with two references requested, identity checks and Disclosure and Barring Service (DBS) checks undertaken. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. Where any issues had been highlighted on a DBS check the acting manager told us this had been discussed at interview and a consideration of the risk made. Records for recently recruited staff showed they had been subject to a formal interview process. Staff confirmed they had been subject to a formal induction process prior to commencing work at the home. This meant the provider had an appropriate system in place to recruit staff.

Accidents and incidents were recorded and monitored by the acting manager. We saw a monthly review was carried out looking at the cause of any incidents, noting any injuries and the action taken and whether people's relatives had been appropriately informed. Where additional action had been taken, this was also noted. For example, one person had been checked to see if they had an infection contributing to a fall. Another person had a falls mat put in place to limit future incidents. This meant incidents were logged, reviewed and action taken, where necessary.

Medicines were managed safely and appropriately. We observed staff supporting people with their medicines and saw people were encouraged and observed to ensure they took their medicines correctly. Medicines were stored in a locked trolley which in turn was stored in a locked clinical room, when not in use. The trolley was very well maintained with bottles and tubes neatly stored and dated when opened. Boxed or bottled items were additionally named to aid identification. Medicine records were neat and tidy and showed no gaps in signatures. Some people received controlled medicines. Controlled medicines are those where there are special laws related to their use and safe storage. We noted these were stored in a locked cupboard. We found the number of controlled items recorded matched the number stored in the cupboard. Staff confirmed they had received additional training in the safe administration of medicines and the acting manager confirmed she had carried out competency checks to ensure staff dealt with medicines safely. This meant people were supported with their medicines and they were managed safely.

Requires Improvement

Is the service effective?

Our findings

The operations director told us training for staff was now provided by a private company, who had been contracted with to deliver training across all the provider's locations. The operations director said the training company was currently evaluating the training needs of all the staff and would be developing future training to address specific staff needs. We saw there was some evidence of a training matrix being maintained at the home and staff files contained evidence of recent training. The operations director said they would ask the training company to forward to us a full and up to date training matrix confirming the current status of staff training at the home. We subsequently received copy of the updated training matrix. Staff we spoke with confirmed they had access to a range of training and development. They told us they had recently undertaken training in moving and handling, infection control and end of life care. Staff also said they were being supported to complete Health and Social Care certificates at various levels, depending on their role. This meant staff were supported to undertake a range of training and gain additional qualifications.

Staff told us they had access to regular supervision with the acting manager or other senior staff at the home. Staff personal files contained records of supervision discussions and showed a range of issues were discussed. Staff said they had had annual appraisals in the past, but none recently. The acting manager said that from auditing staff files she had not found any recent annual appraisals and undertaking them was part of her action list as a new manager. The most recent appraisal records available dated to 2014. Annual appraisals are important to ensure that staff working practise are regularly reviewed and the training and development needs of individual staff members are considered.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The acting manager maintained a list of people who had either had a DoLS granted or an application had been made. Where a DoLS had been granted a copy of the documents was kept on file and a note made when a renewal application or reassessment was required. We saw that a number of DoLS had been appropriately reassessed and applied for. Care records referenced that decisions needed to be taken in people's best interests. However, it was not always evident in people's care plans that decisions taken were specific and detailed the least restrictive options considered. For example, one person had bed rails in place,

which were appropriate for their safety, but it was not clear that a specific best interests assessment had considered all available options. This meant the person, who was not in a position of offer their consent, had their freedom potentially restricted without appropriate safeguards being followed to ensure such actions were the minimum that could be appropriately applied. The acting manager told us she was aware of the needs of the MCA and it was something that she was keen to address as she reviewed people's care. We recommend the provider further reviews the recording and documentation in relation to recording best interests decisions.

Where people did have the capacity to make their own decisions and choices then we saw they had signed consent forms to show their agreement.

People's wellbeing was supported. Records contained a range of information and letters indicating people had attended local hospitals or clinics for appointments, or health professionals had visited the home to review people. We spoke with a health professional who was visiting the home on the day of the inspection. They told us they had no particular concerns about the care delivered at the home and felt staff contacted them appropriately. We saw other health and social care professionals attended the home during both days we were at the home. This meant people were supported to maintain good health and their well-being was supported.

People and relatives told us the meals provided at the home were good and they had plenty to eat and drink. We spent time observing meal times at the home and saw that food was freshly prepared and looked hot and appetising. People where provided with a main meal at lunchtime and a lighter meal at tea time. Staff encouraged people over the meal times and worked hard to support people who need assistance with eating and drinking. We observed staff were very busy over the meal period and spoke to the acting manager about staffing numbers to further support these busy periods. We noted on the first day of the inspection staff did not always interact with people they were supporting and the social side of the mealtime experience was not always well supported. On the second day of the inspection we observed there was better interaction between people and staff during the meal.

We spoke with members of kitchen staff who demonstrated they had a good understanding of people's particular dietary needs and preferences. The acting manager told us one of the things she had been most impressed with since coming to the home was the home cooked meals that were provided. One person told us they had a particular food intolerance and said kitchen staff had spoken to them when they first came to the home, to find out what they would like, or could or could not eat. They said the cook had then prepared a special rice pudding for them, which they said was very nice. People had their weight monitored on a regular basis and where necessary referrals were made to people's general practitioner or other specialist services. This meant people were supported to maintain a good intake of food and fluids.

The acting manager told us that as part of the refurbishment of the home she was looking to improve the environment for people living with dementia and also those with failing senses. She showed us handrails that had been sanded down and she said were going to be painted a more striking colour to make them more visible. There were some pictorial signs around the home indicating bathrooms and toilets. The home also had an extensive accessible garden area with flat access to most of the grounds. Raised flower beds had been built and these contained not only flowers but vegetable and soft fruit. There were seats and tables around the grounds and we saw people were making good use of the area. One person told us the garden was well used and that there were usually more people out and using it than on the day of the inspection.

Good

Is the service caring?

Our findings

People and their relatives told us they felt staff at the home were caring and supportive. Comments from people include, "The staff are all lovely; they have all been very kind" and "(Name of carer) has been here a long time, she is good. She is lovely" and "It's a lovely place to live. The girls are alright; very nice." One person told us about a recent trip to a hospital appointment, where they had been accompanied by a staff member. They told us, "The care worker who came with me looked after me very well. I couldn't believe how good she was. I went straight to the manager after to commend her." A relative told us, "Overall I am quite happy with the care. If (relative) is happy then I'm happy." One staff member told us, "We know the ways and means of people, know the person, know when to step in and know their routines."

We spent time observing the interaction between staff and people who lived at the home and noted staff treated people in a patient, respectful and courteous manner. We saw that, although staff were busy they took time to acknowledge and speak to people whilst they were passing. Several people, who because they were living with dementia, became confused or distressed. Staff responded appropriately, reassuring and supporting people, speaking quietly and using touch in an appropriate manner to comfort them. We witnessed a member of the domestic staff, who was returning from their break, walk past a person and speak with them. As part of the conversation they asked if the person wanted a hot drink. On hearing this, another person sat close by said, "Make that two coffees!" We saw both people were then provided with a drink.

Staff told us no one at the home had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. One person told us about their religious beliefs and said they were supported to continue to practice their religion at the home. They told us, "I've never felt not able to practice; I've always felt free to practice and pray."

People and their relatives told us they were involved in their care and reviewing their care needs. People told us staff had sat with them to understand their particular needs, likes and dislikes. Comments from relatives included, "They keep us updated about things and always ask. If there is a hospital appointment coming up they tell us so we can accompany them." Relatives also said they were able to visit the home at any time. One relative said, "We can pop in any time; early in the morning or late at night. There's no restriction on us seeing how he is." One person told us about their food choices, "I was asked what I like and they made a list of the sorts of things I can have." This meant people and their relatives were involved in determining and reviewing their care needs.

The acting manager told us no one at the home currently used an advocate. She said most people had access to family members who supported them in making their views known. She said there was currently one application in progress for a legal appointee to be put in place for a person who had no close living relatives. We saw in DoLS application documentation that people had been assessed by an IMCA (Independent Mental Capacity Assessor) to ensure their rights were protected within the DoLS process.

Staff understood about respecting people's privacy and dignity. Staff knocked on people's doors before they entered their rooms and that any staff who exited a room when personal care was being delivered did so in a discrete manner. Staff were able to describe how they supported people whilst delivering care, such as ensuring they were covered as much as possible. People were also supported to maintain their independence. We witnessed people walking back and forth to their rooms during the day. We also noted they were able to spend time out in the garden, enjoying the sunshine. One area of the garden had been set aside for people who smoked. People told us they were supported to maintain contact with their families and often went out to lunch or out for the day with them. They said they were also supported to attend local clubs or events in the community. One person told us, "I'm very independent. I always manage everything I want to do." This meant people's privacy was respected and dignity supported and their independence maintained.

Requires Improvement

Is the service responsive?

Our findings

The acting manager told us that one of her priorities since she had arrived at the home had been to review all the care plans and begin to update and revise them. She was engaged in this process at the time of the inspection.

People's needs had been subject to an assessment prior to them coming to the home. Care plans contained good personal information about people's backgrounds, family and personal history. Following these assessments people's particular needs were identified along with objectives they wished to achieve. Care plans addressed areas of need such a mobility issues, skin integrity, medical issues and personal care. Care plans did not always contain sufficient detail for care staff to follow, or did not effectively follow professional advice. For example, one person was noted to be losing weight and needed additional encouragement to eat. They had been referred to the local dietetics service who had made a range of recommendations, one of which was the person should be encouraged to eat through the use of finger foods. Whilst all staff were aware of the particular needs of the individual and that they needed to be encouraged at meals times, and offered additional snacks, the professional advice had not been included in the care plan and we did not observe finger foods being offered to the person.

Another person was of the medicine Digoxin. This medicine is used to treat heart problems and can slow people's heart rate. We noted from the person's MAR that their pulse was regularly recorded before the medicine was given. The acting manager told us she had noted this was not being done when she came to the home and so had instigated this check. However, the person's care plan gave no information about the required checks and no indication what staff should do if the person's pulse was slow. There was also no indication as to the level when staff should be concerned, although the acting manager said that if the person's pulse dropped below 60 then concern would be raised. She agreed care plans could contain more detail and said she would look to do this as part of her overall review process. This meant there was a risk that people would not receive the correct support because care plans did not contain up to date or detailed information for staff to follow.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person Centred Care.

People and staff told us that activities at the home were currently limited. People said there were some events, but more could be done in this area. Staff said they did not always have time to sit and talk to people, but tried to do what they could. We particularly noted there were limited activity opportunities for people living with dementia. We saw from the home's quality improvement questionnaire that five relatives had rated activities at the home as poor or inadequate. The acting manager agreed activities were currently an issue at the home, but said she had recently appointed a new activities co-ordinator and was awaiting DBS and other documentation before the person could take up the appointment. She said she was particularly interested in developing the service in terms of support for people living with dementia. She said she was doing what she could in the interim and said that some people had been out to a local pub the previous day. People who were more independent said they were supported to go out to activities they

enjoyed, such as attending a weekly luncheon club. This meant there were limited activities at the home and limited support for people living with dementia.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person Centred Care.

We spoke with staff, who had a good understanding of people's needs, backgrounds and families. Staff were able to describe the support they gave to certain individuals and their particular preferences and likes and dislikes. Staff said several members of the staff team had been at the home for a considerable period and so had a good understanding of the individuals living there. One person we spoke with told us staff had been particularly responsive to their needs when they had first arrived at the home. They said they had made changes to their room to make it more homely. They also told us the staff approach had helped them settle in, balancing their desire to spend time alone with encouragement to join in with the wider home environment. The commented, "All the staff worked so hard to please me. They provided new curtains and spruced up the room." They also told us how night staff had gone out of their way to make them a snack late one evening and said, "Nothing seems too much trouble." Another person told us how they had been unable to walk when they first came to the home, but had been supported by staff to regain their full mobility. This meant staff had a good understanding of people's day to day care needs and were responsive to people's individual care requirements.

People told us they were able to make choices. They told us they were able to spend time in their rooms on their own or join in with the wider community at the home. One person, who said they were very independent, said they found the home met their needs well and they could very much please themselves. They told us they could ask for different meals, if those offered did not interest them and could chose to take their meals in their rooms, if they wished. One person told us, "I like a bacon sandwich in the morning and they bring one to my room for me."

The provider had a complaints policy in place and information on how a raise a complaint or concern was displayed on the main foyer area of the home. We saw complaints were recorded and a response made, as necessary. The acting manager told us there had been no formal complaints since she had taken up post, but that her door was always open and people or relatives could raise concerns if they had any. People told us they had not made any recent formal complaints and said that if they did raise any concerns these were dealt with immediately. This meant the provider had a complaints policy in place and any concerns were dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager, registered with the CQC for the location, who was no longer working there. We spoke with the operations manager about this and he told us he would immediately take steps to have this manager's name removed from the home's registration. The acting manager at the home told us she had only been in post for about 10 weeks and was still settling in and planning changes that she wished to bring about. She told us she had commenced the process to formally register with the CQC and our records showed the initial stages of registration to be in progress.

The acting manager told us that when she first started at the home she had identified a range of issues that required to be addressed. This had resulted in the commencement of a refurbishing programme at the home and the reviewing of care plans. Although she had only been in post for 10 weeks she felt this had been a good start. She told us this was her first manager's position and the main challenge was understanding that her work would never be done. She said she was constantly walking round looking at and checking on things. She said she wanted to upgrade the home and bring it up to date, whilst keeping the atmosphere homely. The provider and the operations manager both told us they wanted to keep the homely atmosphere of the location.

The provider told us they welcomed the inspection by the CQC, or the local authority, as it brought in fresh eyes to help identify where improvements could be made. He said that any issues that were noted as requiring improving or changing would be dealt with.

The acting manager showed us a range of checks and audits that she had commenced at the home. She said that since starting work at the home she had audited staff files, to see they were all complete, and instigated walk around audits, bedroom audits and medicine audits. Walk around audits were recorded informally, but identified such issues as if curtains required changing, any unpleasant odours in rooms, light bulbs that required replacing and any additional cleaning that was required. Medicine audits also identified some people had not had photographic identification in place or that allergy information was not always available for some people. The audit also checked that regular medicines counts, on how many tablets remained, were accurate. However, the current audit systems had failed to identify issues highlighted in the inspection and provider oversight had not identified the deficits in complying with national HSE guidance. This meant audit systems were not currently robust and fully effective. The acting manager said these systems would be developed as she settled more into the role.

Daily records at the home were well maintained and contained good detail. Care records were stored appropriately and safely within the home. Shift handover records were not always personalised or gave detailed information about people's presentation or progress. There was frequent use of abbreviations such as: SDNC - settled day no concerns, AC - accident occurred or DNV – district nurse visited, rather than information on how the individual had been or what actions had occurred.

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

A range of questionnaires had been distributed and completed to assess people's views of the home in July and August 2016. Nine residents' questionnaires had been returned, although we noted the majority had been written by staff, to record people's views. Eight out of nine people said staff listen to their concerns and everyone questioned said they enjoyed the meals at the home. One professional had returned a questionnaire and rated the home four (out of a top score of five) for all areas. 11 relatives had returned questionnaires. We saw a number of relatives had raised the issue of odours at the home, which had prompted action to renew flooring. Nine relatives had rated the overall care at the home as good or very good.

People told us they knew who the acting manager was and that she was making an impact on the home. People told us, "I've met (acting manager). She seems very good. You can speak with her about things; not a problem" and "The manager has been to see me; I have met her and she seemed to listen to what I had to say." Staff told us the acting manager was bringing about changes at the home they felt were beneficial. The most frequently used phrase was, "firm but fair." Other comments included, "She is lovely. She has been doing everything; very nice and very understanding"; "She is one of those who wants everything perfect. She is one who is very detailed and looks at everything in detail"; (Manager) is a fantastic manager; she is excellent" and "The best manager we have had so far. She seems to be moving things along appropriately. She has made a few changes and is getting the place spruced up. It's taking time but we are getting there."

Staff also told us there was a good staff team at the home and staff supported one another. They told us they were happy working at the home and enjoyed coming to work. Comments from staff included. "If you can do something to help the residents that makes me happy"; "Coming here I get satisfaction from the residents; seeing them smile or say thank you" and "I'm happy here. It's just such a rewarding job. I love it."

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment were not provided in a way that met the needs of service users, as care plans did not always reflect professional advice or contain sufficient detail. Activities at the home were limited, especially those supporting people living with dementia. Regulation 9(1)(b)(2)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure that people who used the service were safe because action had not been taken to mitigate risks through the fitting of appropriate window restrictors. Appropriate action had not been taken to minimise the risks associated with infection control. Regulation 12 (1)(2)(a)(b)(c)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established and operated effectively to ensure compliance with the regulations. Robust monitoring or quality and safety issues had not been established and action not always taken to mitigate risks. Regulation 17 (1)(2)(a)(b).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were not always sufficient numbers of suitable competent and skilled staff to meet the needs of people who used the service. Annual appraisals had not recently been undertaken. Regulation 18(1)(2)(a).