Larchwood Care Homes (South) Limited

Rose Martha Court

Inspection report

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Essex
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28 February 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rose Martha Court Care Home is a residential care home providing personal and nursing care to 45 people aged 65 and over at the time of the inspection. The service can support up to 76 people.

People's experience of using this service and what we found
The delivery of care for people was not always safe. Information relating to people's individual risks was not always recorded or did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the proper and safe use of medicines. The staffing levels and the deployment of staff was not suitable to meet people's care and support needs. Lessons were not learned, and improvements made when things went wrong. People were protected by the prevention and control of infection, but people were not routinely given the opportunity to wash their hands or for antibacterial wipes to be used prior to and after mealtimes. Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Recruitment checks were satisfactory.

Staffs' training was not embedded in their everyday practice. Though staff had completed an orientation induction, not all staff had received an induction when promoted to a different role. Not all staff felt supported or valued by the management team. People at risk of poor nutrition and hydration were not properly and accurately assessed and people did not always have their nutritional and hydration needs met. The premises did not meet people's needs, particularly for people living with dementia. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when needed.

People and their relatives told us they were treated with care and kindness. However, care provided was not always caring or person-centred. This was attributed to inadequate staffing levels and poor deployment of staff, high agency staff usage and the impact this placed on the quality of care people received. Many interactions by staff remained task and routine led. People were not always treated with dignity and respect.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. Where information was recorded this was not always accurate or up-to-date. Palliative and end of life care plans were in place but provided limited information to guide staff on how to provide care to a person who required palliative care and at the end stages of their life. People were not supported or enabled to take part in regular social activities that met their needs.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and

governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection: The last rating for this service was Good. [Published 21 August 2018].

Why we inspected
The inspection was prompted in part due to concerns received about a person receiving poor care and treatment. A decision was made for us to inspect and examine those risks. This incident is subject to further investigation. As a result, this inspection did not examine the circumstances of the incident. The information we received about the incident indicated concerns about safeguarding and protecting people, effective care and support, nutrition and hydration, dignity and respect, personalised care and end of life care.

We have found evidence that the provider needs to make significant improvements. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rose Martha Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors on 25 and 26 February 2020 and one inspector on 28 February 2020. The inspectors were accompanied by two Experts by Experience on 25 February 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Rose Martha Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. However, the registered manager was on extended leave and the service was being managed by a peripatetic manager and the service's regional manager. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 20 people who used the service, 10 relatives and two people who acted on a person's behalf about their experience of the care provided. We spoke with 15 members of staff including senior care staff and care staff. We also spoke with the service's chef, the deputy manager, the peripatetic manager and Regional Area Manager. We reviewed nine people's care files and three staff personnel files. We also looked at a sample of the service's quality assurance systems, the provider's arrangements for managing medication, staff training and supervision records, complaint and compliment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further evidence from the Regional Area Manager of satisfaction questionnaires completed for people using the service, relatives and staff for 2019.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely
• Although staff had received moving and handling training, we observed nine separate incidents whereby staff performed unsafe moving and handling practices. On each occasion staff placed people at potential risk of harm by placing their hands under people's armpits when assisting them with transfers from a wheelchair to a comfortable chair and vice versa. This technique is unsafe, can hurt and cause injury because the person's armpits and shoulders have too much pressure on them. Wheelchairs were placed directly in front of the chair and not an angle to make the transfer safer for the person being transferred and for staff providing support.
• Additionally, one person was brought into the communal lounge on the first floor in their wheelchair. Although footplates were attached and the person's feet were on the footplates, the person's heels skimmed the vinyl flooring, and this was not noticed by staff. This technique is unsafe, can hurt and cause injury because the person's feet could drag along the floor and get caught under the wheelchair.
• Staff told us they were concerned about one person's mobility as they were not always able to weight bear and at these times relied heavily on staff for support. This was not recorded within the person's care file and consideration had not been given to having this person's moving and handling care needs reassessed, for example, by an Occupational Therapist. This placed the person at potential risk of harm. We told the Regional Area Manager and they confirmed this would be addressed.
• There were examples where risk assessments were not followed, did not exist or were not adhered to. For example, two people with known choking risks were not supported in line with their care plan for support and/or repositioning when eating. This action was needed to reduce the risk of harm for both people using the service.
• People using catheters did not have related risks identified such as blockages and urinary infections. This meant people had risks to their health and safety which were reasonably preventable but not being addressed.
• The Medication Administration Records [MAR] for 12 out of 43 people were viewed. These were not in good order as they did not always provide an account of medicines used or demonstrated people were given their medicines as prescribed. There were unexplained gaps on the MAR forms.
•Not everyone had received their prescribed medication as there were not always enough stocks available and topical creams were not routinely applied as information to demonstrate this was not recorded.
• PRN 'as required medication' protocols were not completed for all medicines administered in this way.

Effective arrangements were not in place to mitigate risks for people using the service or ensure medication practices were safe. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staff rosters viewed for the period 23 December 2019 to 26 January 2020, showed staffing levels as stated by the peripatetic manager were not always maintained.
• People's comments about staffing levels were not positive. Comments included, "Daytime staff are stretched to their limits" and, "There are less visible staff, weekends are the worst, they are running around."
• Relative's comments were also negative and included, "At weekends they're [staff] always phoning in sick, then you see on Facebook they've been out. I came in last week and [name] was still in bed at 10.30am. [Name] did not have breakfast until 11.30am, so they didn't want their lunch when it came", "Particularly at weekends there's not enough staff up here [first floor], very often on weekdays too" and, "Before now I've had to stay sitting in a lounge because no staff were available, it's not their fault, they work really hard."
• Staff told us they did not always have time to sit and talk to people. Observations throughout the inspection showed care provided was task and routine focussed and not person-centred.
• The deployment of staff did not meet people's needs. There were several occasions on the first floor whereby communal lounge areas were left without staff support despite some people having behaviours that were inappropriate and which could be challenging to others, placing them at potential risk of harm. On day two of the inspection, an altercation took place between two people, whereby both people were verbally provoking one another, resulting with one person raising their walking stick and threatening to hit the other person. No staff were present during this 15-minute disagreement.
• Insufficient staffing levels and poor deployment of staff meant people on the first floor did not receive their breakfast in a timely manner. On the first day of inspection, staff did not complete peoples personal care until 11.30am. People were left in the dining room for long periods of time despite having finished their breakfast earlier as there was no one available to assist them to the communal lounge. On the first day of inspection the last person was taken to the communal lounge at 11.57am.
• Social activities did not commence until 11.30am and 11.50am respectively on the first two days of inspection as the staff member responsible for facilitating social activities supported people with their breakfast. Without this support, people would not have had their breakfast until much later.
• The systems in place for planning and reviewing staffing levels were not effective to ensure safe numbers of staff for the needs of people using the service. There were staff vacancies, high rate of staff sickness and usage of agency staff.
• People's dependency needs were assessed but not always accurate. For example, the dependency assessment for one person detailed they required one member of staff to assist with washing and dressing. Staff told us this was inaccurate as due to the person's mood and behaviours, they could require two or three staff members. This was not an isolated case.

Sufficient numbers of staff were not deployed effectively to meet people's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• There was a failure to learn lessons from incidents that affected the health, safety and welfare of people using the service and this was not shared with staff. There was no formal system or process in place that ensured each safeguarding concern, complaint or incident was reviewed and monitored to make sure action was taken promptly to remedy the situation and prevent further occurrence. There was no record of actions and lessons learned taken forward from recent events.

• Staff had been recruited safely to ensure they were suitable to work with vulnerable people; however minor improvements were required as not all gaps in employment had been fully explored.
No work place adjustments had been made for staff who had a disability or specific medical condition to ensure they were supported to undertake their role and responsibilities to the best of their ability. This demonstrated the provider does not promote equality and inclusion within its workforce.

Systems and processes to safeguard people from the risk of abuse
• The 'Safeguarding Index' was not legible and did not record outcomes and the actions to be taken to improve practices and prevent reoccurrence.
• People's comments about their safety were positive and included, "All the staff look after me, I do feel safe", "I feel safe here, staff have never been unkind to me" and, "I feel safe living here." Not all relatives felt assured their family member was kept safe.
• Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team, the organisation and external agencies, such as the Local Authority or Care Quality Commission.

Preventing and controlling infection
• People were protected by the prevention and control of infection. The service's infection control and principles of cleanliness were monitored and maintained to a good standard. The premises were clean, odour free and staff used appropriate Personal Protective Equipment [PPE], such as gloves and aprons. Staff told us and records confirmed staff received suitable infection control training.
• The provider was closely following the government guidance on how to manage the recent outbreak of infectious diseases. However, people were not routinely given the opportunity to wash their hands or for antibacterial wipes to be used prior to and after mealtimes.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
• The dining experience for people across the service was variable. The dining environment for people on the ground floor was pleasant but this contrasted with the experience on the first floor.
• People on the first floor were supported at 12.30pm to go to the dining room but the lunchtime meal was not served until 1.18pm. This meant some people had been waiting for over 45 minutes to have their lunchtime meal. There were no conversations between people using the service and there were no staff present to facilitate conversations as they were busy bringing people from the communal lounge to the dining room. Some people became anxious and distressed. One person kept getting up from the table to walk around and one person was overheard to say, "I'm fed up waiting, it's a long time to sit here."
• Some people ate well, whilst others who were sleepy, left a lot of food on their plate for disposal. People were not asked if they had had enough or if they wanted an alternative meal choice. People were not routinely asked if they had enjoyed the meal.
• Though one person preferred a vegetarian diet, this was not provided by staff. The person pointed to the ham on their plate, stating they did not want this. Staff told the person to leave the ham on their plate and to eat the egg and chips, but the person continued to state they did not want the ham on their plate. Eventually the plate was taken away and staff returned the plate, and this had a fried egg and chips. The vegetarian choice of tomato pasta was not offered to this person or others.
• During mid-morning and mid-afternoon refreshments, people were offered a choice of hot drinks and biscuits. Snacks, such as homemade cakes and crisps were readily available on the trolley but not consistently offered to people. This was despite some people's care plans stating they should be offered snacks throughout the day as they were at risk of losing weight.
• Whilst jugs of juice were put out, they were not accessible to most people because they did not have the ability to think about having a drink or to get up and help themselves. This meant they were heavily reliant on staff. Staff failed to give out drinks throughout the day to ensure people remained hydrated.
• People at risk of poor nutrition and hydration were not adequately assessed. The Malnutrition Universal Screening Tool [MUST] for some people was incorrect. MUST is a screening tool used to identify adults who are malnourished, at risk of malnutrition or obese.
• The chef was using a normal hand blender rather than a specialist blender where people were prescribed a textured diet.

Suitable arrangements were not in place to ensure the nutritional and hydration needs of people were met. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• People received care and support from staff who did not always have the skills and competencies to effectively carry out their role.
• The staff training summary provided by the Regional Area Manager, demonstrated the overall percentage of staff having completed mandatory training in line with the registered provider's expectations achieved was 93%. Although our observations showed some staff were effectively able to apply their learning, others were not, and improvements were required to ensure their training was embedded in their everyday practice.
• Staff's understanding of dementia care was not effective, or person centred. One relative told us on occasions two or more staff provided support for their family member, but staff's communication skills meant they were often all speaking at the same time. The relative told us their family member could not cope with this and it exacerbated the situation.
• The service's chef had not received any training in relation to textured diets for people with dysphagia [difficulty swallowing] nor were they aware of the new guidance relating to the International Dysphagia Diet Standardisation Initiative [IDDSI] framework which was introduced in 2019. The chef had been on annual leave when this training was initially provided but this had not been followed by the provider or management team.
• Newly employed staff at Rose Martha Court Care Home had received an 'in-house' orientation induction. Where staff had not attained a recognised qualification and had limited experience in a care setting, staff had completed the 'Care Certificate'. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life.
• The peripatetic manager stated they were mentoring the newly promoted deputy manager. However, there was no evidence to demonstrate this was happening and a robust induction was not evident. A member of care staff who had recently been promoted had not received an induction.
• Though agency staff received an 'orientation' induction, agency staff told us this was rushed and provided little value. Observations during the inspection showed agency staff were not routinely assigned to a member of staff for support and guidance, particularly if this was their first shift at Rose Martha Court Care Home.
• Staff had received formal supervision. However, where issues were raised, evidence relating to how a staff member's performance was to be monitored and lessons learned, was not recorded and checked.

Suitable arrangements were not in place to ensure staffs' training was embedded in their day-to-day practice and not all staff had received an induction relating to their role and responsibilities. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• Staff told us the week prior to our inspection, the peripatetic manager and Regional Area Manager had made the decision that all people residing on the first floor would eat together in two adjoining rooms at one end of a very long corridor and sit together in one communal lounge at the opposite end.
• Observations during the inspection showed this arrangement was not working with the mobilisation of people from one end of the building to the other being chaotic and not enabling staff the opportunity to effectively monitor what was happening on the floor. Staff told us they had not been given a rationale for this decision and people and their relatives had not been consulted. Staff stated, "We now spend all day moving people from one end of the corridor to the other." We discussed this with the Regional Area Manager during feedback and on the third day of inspection this arrangement had reverted to one lounge and one dining room at either end of the building.
• In order to accommodate most people on the first floor to sit within the large communal lounge, comfortable chairs had been moved and placed against the edges of the wall. Staff told us the chairs used

to be placed in small groups to enable people to talk or play games together. On the first day of inspection the peripatetic manager was observed to rearrange the chairs, so they were grouped together in small clusters. When asked about this, the peripatetic manager blamed the night staff for changing the layout. We discussed this with both day and night staff. Staff confirmed the peripatetic manager's justification as stated was not accurate.
• The environment was not appropriate for people living with dementia. There was a lack of visual clues and prompts, including signs using both pictures and text to promote people's orientation. Lighting was poor within the main corridors and did nothing to reduce the potential risk of falls. There were no contrasting colours on the walls as these were painted a plain colour.
• There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format.

We recommend the provider seek national guidance to ensure the premises are suitable to meet people's needs and for the service provided at Rose Martha Court Care Home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission to the service. The quality of the assessments was inconsistent.
• People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their need's assessment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support.
• People had access to healthcare services when they needed it and confirmed their healthcare needs were met. Relatives told us, "They [staff] will always ring if [name] is unwell, they communicate well with the family, even in the middle of the night", "They'll [staff] ring me if there are any issues or worries, they wouldn't keep things from me" and, "Chiropodist comes every six weeks. We take [name of family member] to the dentist and they were recently seen by the GP. They [staff] always get a GP if needed."
• People's oral healthcare needs were assessed and recorded.
• The service was part of the 'Red Bag Care Home Scheme'. The aim is to promote and improve communication and relationships between the care service, ambulance crews and NHS Hospital; enabling relevant healthcare information about a person to be shared.

Ensuring consent to care and treatment in line with law and guidance
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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being

met.

• Staff demonstrated a good understanding and knowledge of the key requirements of the MCA and DoLS.
• Though people's capacity to make decisions had been assessed and these were individual to the person, people were not always supported to have maximum choice and control of their lives. For example, people during the inspection, particularly people residing on the first floor were not able to make a choice relating to where they could sit or have their meals.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People's comments about the quality of care and support they received was positive. People told us staff were kind and caring. Comments included, "I'm impressed with them, really I am, I have no complaints about them, they're good to me", "Staff are kind, try to help, slightest problem they try, it is friendly here" and, "Nice staff, pleasant and helpful."
• Relatives were also positive. Comments included, "I couldn't praise them [staff] highly enough, they have such a difficult job to do. They are very caring and always happy to speak to me about [name of person using the service]" and, "The care is good."
• Staff told us existing staffing levels and the high use of agency staff impacted on the quality of the care people received. Observations demonstrated care provided by staff was primarily focussed on routines and tasks.
• Staff told us they did not have time to sit and talk with people for any meaningful length of time. There was an over reliance on the television or listening to music, despite some people being asleep or disengaged with their surroundings and not watching the television.
• Observations demonstrated not all people's care and support needs were being met in line with their care plans. Information received from one relative suggested their family member's care needs relating to their mobility were not being met or followed up. Following the inspection, we wrote to the provider to ensure this was dealt with.
• Not all staff knew people's care and support needs. For example, not all staff were able to tell us who was at choking risk. The peripatetic manager provided inaccurate information to us regarding one person's ability to understand information and to effectively communicate. We saw an agency member of staff walking with one person, but they were unsteady on their feet. A permanent member of staff passed by whilst assisting another person to mobilise and told the agency member of staff there should be two staff supporting this person. Whilst another member of staff was deployed to provide aid, the person became unsteady and fell towards the wall. The agency staff member told us they had not been given the correct information.

Supporting people to express their views and be involved in making decisions about their care
• Some relatives confirmed they had seen their family member's care plan. Comments included, "I know about [relative's] care plan. I've discussed it in a meeting with a social worker present" and, "I've seen [relative] care plan, I know I can always ask to see it."
• Six monthly reviews for people were not regularly undertaken. The reviews for two people had taken place in March and November 2018. No further evaluations were completed and for one person their family had

not been involved in the process, despite there being active family involvement.

Respecting and promoting people's privacy, dignity and independence
• Although staff were able to tell us how they would uphold people's dignity and treat them with respect, care was not always delivered in a way which respected the person being supported or maintained their dignity.
• Visitors told us they were concerned about their friends clothing as many items had disappeared despite being labelled with the person's name. We went through the person's wardrobe and found only seven out of 16 items of clothing belonged to them. The person's visitors told us when they last visited the service, their friend had been wearing another person's pyjama bottoms. One relative told us their family member did not have their clothes regularly changed. For example, they had recently supported their family member to dress and found them to still be wearing the same clothes three days later. There were also occasions whereby they had found them wearing multiple pairs of socks or underwear.
• Staff told us there were people who required a gender specific member of staff to meet their care and support needs, particularly when they became anxious or distressed. However, our observations showed, there were not always enough gender specific staff available to support people.
• Variable arrangements were in place to support people to remain independent. One person told us they did not know if they were able to weight bear or not as their mobility needs had not been assessed since being admitted to Rose Martha Court Care Home. The person told us, "I would love the opportunity to stand." This did not support the person's potential ability to maintain their independence or provide assurance the service knew what the person's needs were.
• One person told us they were mostly independent. They told us, "I am independent and look after myself. I can get up and go to bed when I choose. I don't like to be bored, got my word search books in my room, watch television in the evenings and listen to the wireless. [Name of staff member responsible for facilitating social activities] asks me to do the tea trolley sometimes."
• People's privacy was respected, and they received support with their personal care in private.
• People were supported to maintain and develop relationships with those close to them. Records showed people received visits from family members and friends.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Findings at this inspection demonstrated people did not always receive care and support that was personalised and responsive to meet their needs. Staff did not always engage with people in a positive way and care throughout the inspection was task and routine led.

• Care plans were not up-to-date or reflective of people's current care needs. This meant there was a risk that relevant information was not captured for use by care staff and professionals or provided enough evidence to show that appropriate care was being provided and delivered.

• The care plan for one person was written by the peripatetic manager who had only been employed at the service since the beginning of January 2020. Though the care plan referred to the person having the health condition of diabetes, there was no personalised plan of care in place detailing how their medical condition impacted on their activities of daily living. A generic information sheet printed from the internet was in place, however this was from an American and not a British organisation, which would have been more relevant.

• Where people could be anxious and distressed and exhibit inappropriate behaviours towards others, information relating to known triggers and specific guidance for staff on how best to support individuals was not always recorded. Where information was recorded relating to specific incidents, evidence of staff interventions to demonstrate the support provided and outcomes was not always recorded.

• Staff spoken with consistently stated they did not have the time to read people's care plans. Staff told us they were reliant on information provided by senior members of staff at handover. However, this was variable depending on the senior member of staff on duty. Several staff told us of occasions whereby they had not been told when people had moved rooms or provided with enough information where a person's needs had changed.

End of life care and support

• There was limited information recorded detailing how a person's palliative care and end of life care symptoms were to be managed to maintain the person's quality of life as much as possible.

• We were not assured that pain management arrangements were robust and managed effectively to ensure people had a comfortable and pain-free death. Pain relief tools were not adequate, particularly for people who lacked capacity and were unable to tell staff if they experienced pain and where this was located.

• Advanced decision directives were recorded but were not comprehensive. The latter sets out if the person has expressed a wish to be cared for at the service or to go to hospital and if potential treatment options have been discussed with the person's GP or relevant healthcare professionals. There was little evidence to show family, friends and others are actively involved in this process.

• Though staff told us they had received online palliative and end of life care training, staff spoken with

including the peripatetic manager, demonstrated a very poor awareness and understanding of this topic and how to deliver effective care and support. Staff were not aware of national guidance, for example, the Gold Standards Framework and National Institute for Health and Care Excellence [NICE] 'End of Life Care for Adults' guidance, published October 2019.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People's and relative's comments about social activities were variable. Positive comments were mostly made on the ground floor and included, "If there is anything going on I do it, like the sing-a-longs. I also walk along this mile-long corridor, got to keep my muscles going" and, "I do crosswords and participate if there is an activity on."
• The service employed two members of staff to facilitate social activities Monday to Friday between 8.00am and 4.00pm. As stated within the domain of 'Safe', inadequate staffing levels and poor deployment of staff impacted on the service's ability to ensure people living at the service have the opportunity to receive and participate in social activities. People confirmed there were no activities at the weekend and staff did not enable or engage people in social activities at these times.
• Social activities did not commence until 11.30am and 11.50am respectively on the first two days of inspection on the first floor, as the staff member responsible for facilitating social activities was observed to support people with their breakfast and preparing the dining rooms for lunch. When activities commenced, these consisted of karaoke to old-time songs and a quiz. People were animated during these activities and seemingly enjoyed the experience.
• Where people remained in their room, the member of staff responsible for facilitating social activities, confirmed one-to-one support was only provided once weekly. Records provided little evidence to demonstrate this was more frequent and meant people were at risk of social isolation.

Suitable arrangements were not in place to make sure people received person-centred care to meet their needs. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• We did not see enough evidence of how AIS had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

Improving care quality in response to complaints or concerns
• Arrangements were in place to record, investigate and respond to any complaints raised with the service. However, robust arrangements were not in place to review and monitor these to make sure actions were taken promptly to remedy the situation and protect people using the service.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

• The leadership and overall management of the service did not ensure it was consistently well-managed and led at both service and provider level. Findings at this inspection demonstrated the provider and management team were not continuously learning, improving care and monitoring potential trends.

• The Area Regional Manager told us there was a closed culture within the service which they were trying to address. They told us this was by the senior management team monitoring staffs' behaviour and practice with a view to improving the day-to-day culture of the service and outcomes for people using the service. This was not happening in practice.

• Quality assurance and governance arrangements at Rose Martha Court Care Home were not reliable or effective in identifying shortfalls in the service. Specific information is cited within this report demonstrating the provider's arrangements for identifying and managing these and areas for development were not robust and required significant improvement. There was a lack of understanding of the risks and issues and the potential impact this had on people using the service and those acting on their behalf.

• The results of audits did not effectively inform the provider's quality monitoring and assurance processes. There was no robust analysis of the information to identify the strengths and weaknesses of the service. Potential trends, themes and root causes were not looked for and examined.

• An action and improvement plan was in place. However, this was not being addressed to ensure a priority risk management approach had been considered, was in place and commenced. For example, the peripatetic manager, Regional Area Manager and deputy manager were concentrating on the service's documentation rather than focussing on care delivery and staffs' practice.

• Improvements made following our inspection in June 2018 had not been sustained and maintained in the longer term.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Since the beginning of January 2020, a peripatetic manager was in place Monday to Friday and the Area Regional Manager visited the service three days a week. The registered manager was on extended leave and the service's previous deputy manager was no longer employed at the service. An internal appointment had been made to fulfil the deputy manager role.

• Relatives comments about the registered manager and management of the service were variable.

Comments included, "[Name] and I have no concerns whatsoever about [relative] being here, I think it's well run, and they look after [relative] to the best of their ability. When [relative] was at home I was always worried about them, but now I'm not, they're in good hands" and, "I didn't see much of the manager who came last April, made changes since then, had some ideas that are not working out well."
• Leadership was not visible and suitable role models were not available to provide support and guidance to staff to enable them to effectively carry out their roles and responsibilities.
• Staff told us they did not feel valued, respected or supported, particularly by the registered manager. Staff told us since the introduction of the peripatetic manager and Regional Area Manager, staff were beginning to feel better supported and stated there was better communication.
• Staff spoken with were not aware of the provider's vision and values or where these were recorded.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's and relatives' views about the quality of service provided.
• Meetings for people using the service and those acting on their behalf were not routinely held. One relative told us, "We had a meeting last week chaired by the Regional Area Manager, which was very good. This was the first meeting arranged for relatives since July 2019." Other relatives spoken with told us they had not been aware of the recent relatives meeting.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Working in partnership with others
• Prior to this inspection there was limited engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people. Following the inspection, the Regional Area Manager had started to strengthen the service's relationships with key organisations, such as the local GP surgery, local District Nurse service and the Dementia Intensive Support Team [DIST].

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 Suitable arrangements were not in place to make sure people received person-centred care to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective arrangements were not in place to mitigate risks for people using the service or ensure medication practices were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Suitable arrangements were not in place to ensure the nutritional and hydration needs of people were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of staff were not deployed effectively to meet people's needs or to ensure staffs' training was embedded in their day-to-day practice and not all staff had received an induction relating to their role and responsibilities.