RV Care Homes Limited

Roseland Care Limited

Inspection report

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13 February 2019
15 February 2019

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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

About the service:
Roseland Care is a care home that provides care for a maximum of 55 adults. At the time of this inspection there were 32 people living at the service. The service comprises of two separate buildings, Roseland Care (nursing) and Lowen House (residential). Roseland Care is a purpose built care service with two floors, one for general nursing and one for dementia nursing. Each floor has a shared lounge and dining room and access to private garden areas. Lowen House is part of an older house situated a short distance from the main building.

What life is like for people using this service:
•□People told us they were happy living at the service. However, two people raised concerns to us about not being able to access staff assistance when needed. The acting manager spoke with these people and was actively resolving their concerns.
•□Staff were not always provided with accurate and up to date information relating to people's needs in some care plans.
•□Risks to people had been identified and assessed in care plans, but the assessments did not always provide staff with clear guidance and direction on how to reduce those risks. For example, where a falls risk and specific situations when the person would stand unaided had been identified in a risk assessment, it did not then provide guidance for staff on how to mitigate that risk. However, we found staff were supporting this person in bed currently, so the person could not fall. When they were out in the chair staff ensured their chair was reclined and they kept a close watch on them.
•□We were able to evidence from the daily monitoring records that staff were providing suitable care to people despite the lack in some cases of accurate care plan records.
•□People received care from staff who had not always completed mandatory training as required. The provider was aware of this and was putting together a comprehensive plan to address this concern.
•□People did not always have their legal rights protected as the service did not know which people had Deprivation of Liberty Safeguards authorisations in place, and could not therefore effectively uphold any conditions that had been put in place in the authorisation. The provider had not notified the Care Quality Commission about the authorisations as they are legally required to do.
•□People had experience low staffing levels for a period of time before this inspection. This had impacted on their experience of care provided. An additional nurse had recently been added to the day shift by the provider, following concerns by the local authority safeguarding unit.
•□Staff were kind and caring but morale was low they reported being very tired, stressed and did not feel valued and well supported. Supervision had not been regularly provided to all staff.
•□Quality assurance processes were not effective and did not pick up the concerns identified at this inspection.
•□People had completed a survey in 2018 giving their views and experiences of living at Roseland Court, the responses were mainly positive at that time.
•□The premises were in good condition and provided a spacious, warm and relaxed environment for

people.

More information is in Detailed Findings below

Rating at last inspection: Good (report published 18/09/2018)

Why we inspected: We bought this inspection forward due to the high number of concerns raised to the Care Quality Commission (CQC) by the local authority safeguarding unit, the clinical commissioning group and whistle-blowers. Concerns had been raised about low staffing levels which had led to poor care provision for people. There were concerns raised about poor personal care, dirty bed linen, some people did not have call bells available to them. Some people had pressure damage to their skin and this had not been appropriately escalated and referred to external professionals for advice. One person had lost a considerable amount of weight but the care plan had not been reviewed to address this concern. Communication between nurses was of concern with changes in people's condition not always being effective escalated for advice. Dressings were not always being effectively and robustly managed. There had been medicine errors reported and there was concern that people did not always receive their medicines in a timely manner.

We found that people had experienced low staffing levels which had led to two people raising their concerns to staff. People were clean and received appropriate care. However, some people did not always have calls bells within their reach and one person's call bell was missing completely until inspectors raised this issue. There was concern about how some dressings were documented and managed by nurses. Weight loss was being appropriately managed by care staff, however, the care plans did not always accurately reflect what care was being provided. Medicines were managed and administered safely, although we have made a recommendation about one aspect of medicines management in the Safe section of this report.

Follow up: We have asked the service to provide us with an action plan with a specific deadline addressing the key concerns identified during this inspection. We will meet with the provider once this has been sent to us to check what improvements have been and are planned to be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Requires Improvement**

Roseland Care Limited

Detailed findings

Background to this inspection

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

Inspection team:
This inspection was carried out by three inspectors, a member on the CQC medicines team and an expert by experience. 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:
Roseland Care is a care home that provides nursing and personal care for up to 55 people. There were 32 people using the service at the time of this inspection.

People in care homes receive accommodation and nursing or personal care as 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 did have a manager registered with the Care Quality Commission. 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. However, the registered manager had been away on long term sick leave and had not been present at the service for some months. The provider had notified CQC about this. The provider had appointed an acting manager to work in the service during the week. They had been present for the three weeks prior to this inspection.

Notice of inspection:
This inspection was unannounced. We visited the service on the 12, 13 and 15 February 2019

What we did:

Before the inspection we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority commissioners, safeguarding unit, clinical commissioning group (CCG) and other professionals who work with the service. We used all this information to plan our inspection.

During the inspection visits we spoke with15 people who use the service, five relatives and10 staff. We reviewed a range of records. This included 11 people's care records. We reviewed medicine records and looked at three staff files. Various records relating to training and supervision of staff, records relating to the management of the service and records of any meetings held were seen.

Requires Improvement

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Staffing and recruitment

- The provider assured us they were regularly using a robust dependency assessment tool to determine how many staff were required to meet the needs of people living at the service. We were told this was done at least once a month. However, we noted in several care plans that the last dependency score was over a month ago. This meant that the provider may not have accurate up to date information on the dependency of the people living at the service.
- People had experienced low staffing numbers over the recent weeks prior to this inspection. This had led to some people experiencing poor care and delays in receiving care. Rotas showed that over the last month there had been fluctuating levels of staffing, it showed mostly one nurse was supporting between three and five care staff on duty for both floors of the nursing unit, providing care for 21 people. Many people on the nursing unit required two staff for all care tasks. During our inspection on the nursing unit there was one nurse and three carers and on the dementia care unit below, there was one nurse and two carers. The residential building which is a separate building from the nursing unit, had two care staff on duty supporting 11 people, three of which required two staff for all care tasks. However, the provider had recently increased the nursing staff by one nurse on each day shift due to concerns raised by the local authority. There were now two nurses on each day shift, although the provider had only planned this to be for two weeks initially. We were not confident that people would continue to be safe if the staffing levels dropped from what was in place at the time of this inspection.
- People's views on staffing levels varied. The maximum amount of time one person felt was acceptable to wait for staff to support them when called, was 30 minutes. One person said they had waited, on one occasion, for an hour or more. Another person told us, "Two members of staff attend to me when I need to go to the toilet, with the use of the hoist. I can't fault them, sometimes I have to wait, but not too long".
- People and staff told us that the recent increase in nursing staff had made a considerable improvement to the quality and timeliness of the care and support provided. However, on the residential unit it was difficult to find staff as the two on duty were often busy in a person's room providing care and support. This meant other people could not obtain help as needed in a timely way. The provider assured us the deployment of staff was being reviewed.
- Recruitment processes were overseen at provider level. We saw there was evidence of suitable references having been received and DBS checks had been made. This helped ensure staff were suitable to work alone with vulnerable people. We did not see any evidence of the induction programme undertaken. We were assured by the provider this took place and that records were with the staff member for completion.

Systems and processes to safeguard people from abuse.

- Staff knew how to raise any concerns they had about possible abuse. Staff confirmed they had raised

concerns themselves recently to the safeguarding unit.
•□Everyone we spoke with told us they felt safe living at the service.
•□Safeguarding training was provided by the service. The provider was aware that some staff required to have this training refreshed and arrangements were in place for this to be done.

Assessing risk, safety monitoring and management
•□Staff understood what support people required to reduce the risk of avoidable harm. Personalised risk assessments identified specific risks and recorded them.
•□Some care plans did not always describe measures for staff to reduce risks as much as possible. However, staff were providing appropriate care for people despite the lack of guidance in some care plans.

Using medicines safely
- There had been medicine errors reported by the service prior to this inspection.
- Concerns had been raised about the administration of time specific medicines.

•□People received their medicines in a safe and timely manner.
•□Medicines were stored, ordered and recorded appropriately.
•□Nurses and senior carers administered medicines. Staff undertook online training and had their competence to administer medicines assessed regularly.
•□There was a medicines policy. Protocols were in place to give staff additional guidance about when to give 'when required' medicines. However, on the nursing unit, the instructions on these protocols did not always match the directions on the medicine administration record (MAR) and was not always person centred.
•□Some people required to have their medicines covertly. This meant medicines were hidden in food or drink. Whilst there were covert plans in place, they did not always cover all the medicines the person was prescribed. This meant if the person refused their other medicines there was no agreement in place for staff to give them all covertly.
•□There was not always a best interest decision in place to ensure covert was the least restrictive way to give their medicines, or in the person's best interests.
•□People's medicines support needs were identified and recorded on their medication profiles For example, whether they had any swallowing difficulties, what fluids they liked to take medicines with.
•□We recommend the service takes advice and guidance on the best practice for medicines administration in care homes.

Preventing and controlling infection
•□People were protected from cross infection. The service appeared clean and odour free. One person told us, "The home is spotless."
•□Staff had access to personal protective clothing (PPE) we saw it being used appropriately by staff throughout the inspection visits.
•□Records showed that approximately half of the staff required infection control training to be refreshed. The provider was aware of this issue and was making arrangements to address it.
•□The housekeeper showed us robust cleaning schedules were in place.

Learning lessons when things go wrong
•□Accidents and incidents were reported and monitored by the acting manager. Regular reports were sent to the provider. There were actions recorded to help reduce the risk of re-occurrence.

• The provider had been made aware of a number of specific concerns relating to the quality of the care and support provided at Roseland Care. A number of senior managers representing the provider, including the managing director were present in the service during this inspection. The focus was on transferring records to a new format and supporting staff with HR and training needs. Support and guidance was being provided to the acting manager.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Legal requirements were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•□People were assessed before moving to live at Roseland Care. This was to ensure that their specific needs and expectations could be met.

•□Care needs were assessed, recorded, monitored and reviewed. However, this process was not always robust. We noted that staff were providing care and support which was not always recorded in the care plans. For example, a food record was being kept for one person who had lost weight and the person was gaining weight. This was not recorded in the care plan.

•□One newly formatted care plan indicated a person was at risk of skin damage and required re-positioning. Staff were not re-positioning this person. We asked a senior manager about this and we were told, "There is no clinical indication for this person to be re-positioned, the care plan must be wrong." This indicated the clear discrepancy in what some care plans were indicating, people's needs and what care was being provided.

•□People were asked for their preferences and choices. Care records held some evidence of this information. Food preferences were recorded when discussed with the kitchen staff.

•□There was very little life history in some care files. Life history is important as it provides staff with a picture of how the person used to be and provides useful lines of conversation and activity.

- This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff skills, knowledge and experience

•□Staff did not feel well supported. They were very tired, stressed and tearful when spoken with during both days of the inspection. Staff reported feeling demoralised, not valued or recognised for the many extra shifts they had done to try to cover the shortages of staff for the past few months. Some staff had been required to work every day over the whole of Christmas to cover unplanned staff absences. Staff reported being contacted repeatedly, by senior management, when off duty, off sick or on leave, and put under pressure to come in to work due to shortages of staff. Staff told us, "There is more emphasis on completing the paperwork at the moment than providing good care" and "They have got five star paperwork with one star care."

- One relative told us, "There should be more staff on duty to meet the needs of people".

•□Some staff had not been shown how to use the sliding sheets provided to move people in bed. These sheets had been identified as issued for staff use with each person, but were found buried in wardrobes, unused by staff. Staff had recently been requested to use the slide sheets when moving people in bed following concerns from the tissue viability nurses. Staff told us they were not clear on their use. This meant

there was a risk of staff potentially causing skin damage to people when using them inappropriately.
•□Mandatory and additional training was available to staff. The provider held a record which showed that staff training had expired in many cases and was due to be refreshed. Not all staff had been provided with the required mandatory training. This was recognised by the provider and there were arrangements in place for this to be addressed.
•□Staff told us that carrying out training at their home had been stopped and staff were expected to do the training in work time. Staff told us that this was difficult and staff were so busy and did not have enough time to complete the training. This was given as the reason by staff as to why training had declined
•□Following the inspection visits the provider sent us details of the training undertaken by the three newest staff. One of these people had not completed all the mandatory training necessary. We asked the acting manager about this but we did not receive any assurance on this issue.
•□Staff had not had regular supervision over recent months but told us supervision for some staff had been recommenced. Staff told us they would like more one to one supervision and support but at present there was, 'no one to sit down and listen to you.'
•□Supervision is most effective when provided by a person who has good knowledge of the individuals working practices and has an understanding of their background and personal circumstances. Nurses had been provided with supervision by nursing staff from another service outside of Cornwall. The supervisors had no knowledge of the staff they were supervising or the people living at the service. This meant it was not a useful process for the nurses.
•□The provider could not produce records of which staff had been supported by supervision prior to January 2019. This list provided to show which staff had been supervised in January 2019 held nursing and care staff names with ticks against some, no dates were provided. no ancillary staff appeared on this list. The service did not have a robust overview of when all staff would need supervision.
•□The nurses and care staff told us they had worked many back to back shifts with little time off and were very tired. They reported being "pulled from pillar to post relentlessly" and "Spoken to like we were children,"
•□Nurses were given the responsibility of doing the staffing rota but there was no management overview or support to plan ahead for staff leave or sickness absence. Due to the shortages of staff recently the nurses had found themselves having to do the rotas in their own time.
•□This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing
•□One member of staff was pleased to tell us that they had successfully achieved their level 3 training award in the Qualification Credit Framework (QCF). They told us that, "I like it here and would like to improve my knowledge". We were not made aware of any other specific staff having completed this. The provider was in the process of accurately recording staff training requirements.

Supporting people to eat and drink enough with choice in a balanced diet
•□People had a good dining experience in the dining rooms. People were served their meals on tables set with tablecloths, condiments and napkins. Staff were available to support people with their meals.
•□We heard staff chatting with people about what they would like to eat and how much they would like. Alternatives were offered if needed. People told us the food was always hot and there was a choice.
•□People told us, "Food is very good, in fact, I'm over fed," "Water jugs are filled up every day and I'm asked regularly do I want a cup of tea?" and "I've never gone short of anything here."
•□Staff recorded what people ate and drank when required. These records were detailed and stated how much of a meal or drink the person had enjoyed.
•□There had been concerns raised about people being thirsty and unable to easily access drinks. Whilst people all had jugs of water or juice and beakers nearby them, some people needed encouragement to

drink. Not all the people who needed support to drink were having their fluid intake monitored so it was difficult to establish if they drank sufficient quantities.

- We recommend the service take advice and guidance from a reputable source on assessing and monitoring fluid intake for people who are unable to drink independently.

Adapting service, design, decoration to meet people's needs

- The nursing and dementia care units were in a modern purpose built building. There were spacious corridors and wide door ways for people using a wheelchair.
- Ceiling tracks for hoists were seen in rooms providing easy access to moving and handling equipment.
- There were some carpets which were badly stained in some corridors. We noted this at our last inspection and were assured the carpets would be replaced. This had not taken place.
- The dementia care unit had some pictorial signage to help people living with dementia to recognise their surroundings. For example, pictures of toilets and baths clearly indicated to the person what was behind each door. The environment had different colours on doors and walls to differentiate between different areas in the unit.
- The dementia unit had individualised pictures or words on bedroom doors to help people recognise their own room.

Supporting people to live healthier lives, access healthcare services and support

- People had access to their GP and other healthcare professionals such as tissue viability and social workers as necessary. Records of such visits were seen in care files.
- Staff were sometimes able to support people to attend appointments at hospital.
- One relative told us, "We were delighted that an eye appointment had been kept and a member of staff was thanked for their efforts and kindness when escorting my husband"
- One person told us they had experienced sudden hearing difficulties and was happy to report that the service had arranged for a hearing test whilst they recovered sufficiently to return home.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The provider did not know which people living at Roseland Care had DoLS authorisations in place. We checked with the DoLS team who told us that there were three people with authorisations in place. Two of them had a number of specific conditions set within the authorisation. As the provider did not know about these authorisations the conditions may not be upheld, monitored or reported back as required to the local DoLS team. The DoLS team confirmed they had written to the service in November 2018 asking for confirmation that people's conditions were being met but received no response.

- The requirements of the MCA and the associated DOLS was not fully understood by some of the staff. Staff told us that they felt they would like more training in MCA and DoLS. However, staff were able to

demonstrate that they understood the issues surrounding consent and how they would support people who lacked the capacity to make specific decisions. For example, they said they would give people alternatives so they could make a choice.

•□People were asked for their consent before they received any care and treatment and staff acted in accordance with their wishes. However, there was little evidence that everyone was being asked to consent to their care being provided and the content of their own care plans.

•□It was not clear if people had any lasting powers of attorney appointed. This meant that staff would not know which relative or friend, if any, could be asked to support decision making if the person themselves could not do this.

•□This is a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Good

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- Care plans provided staff with some information on people's backgrounds, life history and specific preferences. However, care plan information had been often found to be inconsistent and inaccurate in places.
- Most people gave positive feedback about staff. People's comments included, "Wonderful" and "They are always kind, patient and friendly towards me".
- People's bedrooms were bright and airy with things around them that were meaningful to them. People were encouraged to bring in anything that made them feel comfortable.
- Staff interacted with people well and they gave people time to express themselves. However, one relative told us. "Communication could be better" and "I would like to be involved in my relatives care plan". We noted that families were not always given the opportunity to be involved in their relatives care plan reviews. Where a person was unable to contribute to their own care plan important information about the person's specific requirements could be missed if not discussed with families.
- People's beliefs and wishes were supported. Relatives told us they could visit anytime and staff supported them and made them feel part of the service. One relative explained that it was important to them, "A room was made available to us, as a family, at Christmas and we enjoyed spending time together, which was very special".
- Another relative told us that their relative had been given a more suitable room, so they could enjoy a view of the garden as well as accommodate their mobility aids which are bulky, they said they felt the service had been very helpful.

Supporting people to express their views and be involved in making decisions about their care

- People were invited to shared their views and experiences in a survey sent out in 2018. The responses received (25%) to that survey were mostly positive.
- People were able to join in residents and family meetings to share their experiences and make suggestions to improve the service where necessary. We asked for the minutes of the most recent meeting but they had not been typed up by the managing director and were not provided.
- People were able to choose when they got up or went to bed. During the inspection we saw people we asked there they would like to spend their time and how.
- People knew how to raise any concerns they had. Most were confident they would be listened to, however two people did not feel their concerns had bought about any change. Their concerns were around staffing levels.
- One visitor told us, "This is a lovely home, we come every week and we couldn't ask for more. Staff are

friendly and always make us welcome, we feel very blessed to have our friend here".

Respecting and promoting people's privacy, dignity and independence
•□We saw positive interactions during the inspection between people and the staff. For example, staff advised a resident that they might be too hot, sat in so many clothes, and sheltered her from the glare of the sun whilst they waited to be picked up for an outing.
•□Staff chatted with people each time they passed by or visited them in their rooms.
•□Staff closed bedroom doors when providing personal care and signs were hung on the outside of the door to inform anyone wishing to enter, advising people care was in process.
•□People appeared clean and well cared for.
•□People were free to spend their time where they wished and go out as they pleased. The dementia unit was secured by coded doors and lift access to help ensure people did not put themselves at risk by leaving unsupported.
•□Visitors could call at any time. We saw people coming and going throughout the inspection.
•□People told us, "The staff listen and know what we like and dislike, they are very kind and gentle".
•□Overwhelmingly, people and relatives alike told us the staff treated them with respect and courtesy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

People's needs were not always met. Regulations were not met.

Personalised care

•Care plans were in the process of being changed to a new format by the provider. Three staff, from another home in the group, had been bought in to do this work which took place during the first day of our inspection. Large numbers of care plans were transferred during this inspection. However, we found inaccurate, incomplete and out of date information had been transferred in to some new format care plans.

• The process of changing over the care plans from one format to another did not entail a thorough care review of the person, therefore conflicting information had been copied over into the new format.

•Staff told us that they would like to contribute to care planning because they know so much about the people but the plans are being updated by staff from another service.

•Staff were not always provided with guidance and direction to provide person centred care. One care plan stated a person was, "Severely incontinent has needed catheterisation on retention". In another part of the care plan under a different section it stated "wears incontinence pads". Staff we spoke with were not recording the person's output, only if the pad was wet. Staff were not able to judge if the person was retaining urine and may need catheterisation.

•People's who were living with specific conditions such as diabetes or epilepsy did not have specific care plans to direct staff with guidance on how to support their condition. However, we judged that staff were providing appropriate timely care to people at the time of this inspection.

•One person's care plan stated a person did, and then later in the same care plan did not, have diabetes. However, we found staff were managing diabetes care appropriately.

•Daily monitoring records kept by staff in people's bedrooms evidenced appropriate care. These files contained daily body maps, personal care charts, bed rail checks and any other specific charts required by some people such as their food and fluid intake being recorded. We found these charts were mostly well completed, with a few gaps.

• As reported earlier in the report there were some people who required assistance to drink who did not appear to drink much throughout our visits. They were not having their intake recorded. We have made a recommendation about this in the Effective section of this report.

•There had been concerns raised about the process used by nurses to manage dressings at Roseland Care

• There was a lack of detail recorded by nurses in care plans when some dressings were changed. It was difficult to track what dressings had been applied and when they were next due to be changed.

•A white board was used in the records office on one floor listing dressing requirements for people. We noted some dressings had been ticked off as done but no review date had been set.

•The service used a number of agency nurses often covering nursing shifts and the lack of information in

some care plans and on the white board had led, in the past, to inconsistent care provision. The potential for this to continue remained. We discussed this with the acting manager and we were assured this would be addressed.

•□Where tissue viability nurses (TVN) had reviewed people who needed dressings the guidance was clear for staff. This was because the TVN had documented the details clearly. Some people had more than one wound requiring dressing. However, there was not always separate clearly marked care plans for each dressing. This meant it was not easy to find the information required for each dressing, as notes were often made in the daily records. The nurse on duty accepted this concern and assured us this would be addressed.

- A recent report from the TVN had highlighted a number of people who did not have access to a call bell.
- Three people were found at inspection to not have access to a call bell at our inspection. Two were inaccessible by the person, one was missing completely for both days of the inspection. This was replaced following the inspector raising this issue.

•□This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust systems and processes in place to assess, monitor and improve the quality and safety of the service provided to people.

•□There were audits of pressure mattresses in use to protect people from skin damage. The audit checked the mattresses were set correct for the person. This meant it reduced the risk of people developing pressure areas. Most of the mattresses we checked were set correctly. There was one setting which was a 'guess' as the person could not be weighed due to their healthcare needs. The service was not using the option of arm circumference to calculate the weight of a person in such a situation.

•□People's ability to access information was recorded. Each person's care plan included a section about their individual communication needs. For example, about any visual problems or hearing loss and instructions for staff about how to help people communicate effectively. We saw staff talking with people about meal choices and if they required their glasses. One person was deaf and so staff used a white board to write down anything the person did not understand.

- One person had gone without their hearing aids for a long period and this had meant that the person was unable to hear what was being said, listen to music or watch television unless there were subtitles. The reported loss of this person's hearing aids had been made some time prior to this inspection but the person was still without their aids. It was unclear from the records what action had been taken about this issue. We asked the acting manager to address this.

•□People were provided with activities. One person told us, there was 'plenty to do.' We saw activities were clearly recorded in people's care plans. Visiting animals and musicians were some of the activities provided. One to one activity was provided for people in their rooms. People were supported to go out in to the local community.

Improving care quality in response to complaints or concerns

•□There had been a number of concerns raised to the provider relating to specific people living at Roseland Care. Concerns were around poor personal care provision, poor communication to other healthcare professionals when people's needs had changed and shortages of staff.

•□The provider had not taken a risk based focused approach to comprehensively reviewing the people about whom concerns had been raised by safeguarding and tissue viability nurses. Some of these people had not had a robust review of their care plan at the time of this inspection. However, we were able to evidence that their care outcomes had improved and we judged they were receiving appropriate care at the time of this inspection.

•□Staff told us they had repeatedly reported being tired and stressed due to prolonged periods of staff shortages. This had not led to action by the provider. However, additional staff support had recently been

provided following concerns raised by the local authority.

•□One visitor told us "My relation stays in bed all the time" and "The reason my relation came here is because we thought she would receive support to get out of bed but this doesn't happen". The relation told us they have made complaints all the time but nothing seemed to be done. Two people told us they had raised concerns with staff about delays to them being able to access care and support but they also told us nothing had changed.

• The acting manager had only been in post for three weeks prior to this inspection. It appeared people had raised their concerns to care staff and nurses but this had not been communicated to management.

•□The complaints log held by the service, did not show any of the concerns raised to us during this inspection. The acting manager appeared unaware of the concerns when we discussed them but we received assurance the following day that each person had been talked to and their concerns were being resolved.

•□One person had an early hospital appointment for the second time, as the first appointment had to be cancelled because the person was not ready. The relative told us they made specific prior arrangements to escort the person on this second appointment. The relative said they paid a lot of money for the taxi and when they arrived at Roseland Care their relative was still in bed so the appointment was missed for the second time.

•□This shows the staff and management at the service were not responsive to concerns raised and issues reoccurred.

•□This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not act on feedback from people and others.

End of life care and support

•□There was little evidence that people had been asked for their wishes regarding their end of life care. The new format care plan did not direct staff to initiate this discussion with people.

•□Some people had been assessed by a doctor with regards to the action to be taken should they have a heart attack.

•□People were supported to have comfortable, dignified and pain free death. Nursing staff ensured medical support and appropriate medicines were held to be used as needed. Staff told us about people who had recently died at the service with obvious fondness.

Requires Improvement

Is the service well-led?

Our findings

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations have not been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- As stated in the other sections of this report the care plan transfer to the new format was not carried out in a risk based person centred manner.
- Staff did not give us positive feedback about the recent leadership of the service. They reported feeling 'dismissed' and 'spoken to like a child'.
- Staff told us that they had been threatened with disciplinary action if they did not work when asked or complete all paperwork needed.
- Following this inspection inspectors requested additional information some of which took a few days to be provided, some was not received.
- Staff told us that there was not an open culture within the service which did not make them feel confident in making suggestions without fear of victimisation.
- At the end of the second day of this inspection headline verbal feedback was provided. The medicines inspection took place two days after the initial visit and so needed to be included in written formal feedback once completed. Formal feedback was sent to the provider and acting manager once the inspections visits concluded. The managing director was open and candid in receiving our feedback stating, "If you had not found issues I would have been very shocked." The acting manager thanked the inspector for the way the inspection was handled and gave assurances that all concerns would be addressed.

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

- The provider was not aware which people living at the service were under the restriction of a DoLS authorisation. The provider is legally required to notify CQC of any DoLS authorisations in place. This had not been done.
- Audits which had been carried out on care plans during January 2019 were not robust or effective. We saw many audit documents which were filed in care plans showing lists of actions to be taken. For example, DoLS applications to be recorded clearly in files. Many of the actions had not be made.
- Audits of daily monitoring records were seen carried out using a red pen to indicate changes that were required. However, these audits did not identify the discrepancies we found between what care was being appropriately provided by care staff and what the care plan directed.
- This is a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust systems and processes in place in order to continually assess, monitor, evaluate and improve the service provided.

- The provider was reporting other notifications to us as required by law. For example, deaths, abuse concerns and events that stop the service.
- The service rating from our last inspection was being displayed in the service.

Engaging and involving people using the service, the public and staff

•□People were given the opportunity to express their views at residents and family meetings. One such meeting had been held recently. We requested the minutes of this meeting but this was not received.
•□The staff did not feel they were involved in any of the changes the provider was attempting to bring in. A staff meeting had been held in January 2018 however, we requested the minutes of this meeting but this was not received.
- Care staff told us they no longer attended the handover at the beginning of their shift, instead a handover was given from night nurse to day nurse at the beginning of the day and the nurse then had the role of communicating information to the care staff. We were told that due to staffing shortages, the nurses were often from an agency or too busy to pass on information in a timely manner. Staff told us they felt this was 'unsettling' as they would begin a shift not knowing about the night before. For example, had a person slept badly therefore be offered a lie in rather than supported to get up first thing.
•□A survey had been sent out to people and relatives in 2018, the responses to which were mostly positive

Continuous learning and improving care

•□The provider had been made aware of a number of concerns about the quality of the care provided to people. There had been reports sent to the provider naming each person and clear details of the specific concerns found by the safeguarding and tissue viability team. The provider had not always focused on thoroughly reviewing these people's care plans to ensure it reflected their current needs. However, we found that appropriate care was being provided by the staff.
•□People living at the service were not aware of who the acting manager was and who to raise their concerns to at the time of this inspection
•□The provider told us they had a "very robust risk register assessment" that had been put in place to address the concerns raised to them recently by safeguarding and tissue viability staff. Some people who had been specifically named in concerns, had not had their risk assessments comprehensively reviewed, or dependency scores reviewed and documented at the time of this inspection.
•□Staff reported being put under extreme pressure to complete new paperwork bought in by the provider. Audit checks were being made by senior management of daily records completed by the staff, using a red pen. However, this audit process had not been effective in identifying that some care plan guidance did not match with the care and support being provided.
•□Staff training had not been effectively monitored to ensure all mandatory training and updates were provided in a timely manner.
•□The provider had been asked if any staff working at Roseland Care participated in any local best practice groups. We were told this had happened in the past but did not happen currently.
•□The lack of robust and effective quality and safety monitoring systems were a breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Working in partnership with others
•□Some staff working at the service had in the past attended a best practice group in the local area. We were told this had ceased. No staff at the service were currently attending any specific groups where they

could gain knowledge on best practice.
•□Care records showed regular visits by people's GP and other healthcare workers.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. If the service user in unable to give consent they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be establish and operated effectively to assess, monitor and improve the quality and safety of the services provided. Systems and process must be established to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider must seek and act on feedback from relevant persons and other persons on the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider must receive such appropriate support, training ,professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.