

Heltcorp Limited

# Rotherwood Care Home

## Inspection report

Doncaster Road  
East Dene  
Rotherham  
South Yorkshire  
S65 2DA

Tel: 01709820025

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection was unannounced, and took place on 5th January 2017. The home was last inspected in December 2015, where concerns were identified in relation to how medication was managed, how staff were supported and the lack of a registered manager. At this inspection we found these issues had been addressed.

Rotherwood is a 27 bed service providing residential care to older people with a range of support needs including dementia. It provides accommodation on either a long term basis, or on a short term respite basis including assisting people to rehabilitate following injury or illness before returning to their own home.

Rotherwood is located in the East Dene suburb of Rotherham, South Yorkshire. It is in its own grounds in a quiet, residential area, but close to the town centre and public transport links.

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

At the inspection, we found that staff spoke to people with warmth and respect, and day to day procedures within the home took into account people's privacy and dignity. The home was undergoing a programme of improvements to make the environment more suitable for the needs of people with dementia.

Staff had received training to enhance their understanding, although we noted a small number of staff still required this training. Medicines were stored and handled safely, although we noted some areas for improvement, which the provider addressed immediately.

Where people were at risk of injuring themselves or others, there were appropriate risk assessments in place to guide staff in relation to caring for people safely. Recruitment procedures were sufficiently robust to ensure people's safety.

The service was not always effective, as improvements were required in the way consent was obtained and recorded, and in the way the service responded when people did not have the capacity to consent to their care.

Mealtimes were observed to be comfortable and pleasant experiences for people, and people told us they enjoyed their food.

The home had an activities coordinator whose role involved designing and leading an activities programme for people using the service. We observed activities taking place and saw that people appeared to enjoy this.

There was a formal complaints procedure in place, and we saw that where complaints had been received the provider carried out a thorough investigation and responded to complainants in a timely manner.

The home's manager understood the responsibilities of their role, and they were supported by an operations manager who also had a good knowledge of the home and the people living there.

The management team were accessible and were familiar to people using the service. The provider had a thorough system in place for monitoring the quality of service people received.

## 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. Staff had received training to enhance their understanding, although we noted a small number of staff still required this training.

Medicines were stored and handled safely, although we noted some areas for improvement, which the provider addressed immediately.

Where people were at risk of injuring themselves or others, there were appropriate risk assessments in place to guide staff in relation to caring for people safely.

Recruitment procedures were sufficiently robust to ensure people's safety.

Good 

### Is the service effective?

The service was not always effective, as improvements were required in the way consent was obtained and recorded, and in the way the service responded when people did not have the capacity to consent to their care.

Mealtimes were observed to be comfortable and pleasant experiences for people, and people told us they enjoyed their food.

Requires Improvement 

### Is the service caring?

The service was caring. We found that staff spoke to people with warmth and respect, and day to day procedures within the home took into account people's privacy and dignity.

The home was undergoing a programme of improvements to make the environment more suitable for the needs of people with dementia.

Good 

### Is the service responsive?

The service was responsive. The home had an activities coordinator whose role involved designing and leading an activities programme for people using the service. We observed

Good 

activities taking place and saw that people appeared to enjoy this.

There was a formal complaints procedure in place, and we saw that where complaints had been received the provider carried out a thorough investigation and responded to complainants in a timely manner.

### **Is the service well-led?**

The service was not always well led. The management team were accessible and were familiar to people using the service. The provider had a thorough system in place for monitoring the quality of service people received.

The provider was failing to comply with legislation in relation to the requirement to display their CQC rating on their website.

**Requires Improvement** ●

# Rotherwood Care Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit took place on the 5th January 2017. The inspection was carried out by an adult social care inspector.

During the inspection we checked records relating to the management of the home, team meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the home's management team and senior managers. We spoke with people using the service, staff and the management team.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to make decisions and engage in activities, and using specific pieces of equipment to support people's mobility. We observed a mealtime taking place in the home. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned prior to the inspection

# Is the service safe?

## Our findings

We asked people using the service whether they felt safe at Rotherwood. Everyone we spoke with responded positively, with one person telling us: "We're all safe here, I've got no worries."

During the two days of the inspection we observed that there were staff on duty in sufficient numbers in order to keep people safe. The registered manager told us that they regularly reviewed staffing figures to ensure they were able to meet people's needs. Staff we spoke with told us that the staffing configuration had recently changed but that they were able to meet people's needs. Whenever we saw someone ask for help or support, staff were very quickly available to assist.

We found that staff received training in the safeguarding of vulnerable adults, although noted a small number of staff who still required this training. We spoke with the registered manager about this, and they told us this was because they were waiting for the local authority to run their next course as they considered this to be the best available training. There was information available throughout the service to inform staff, people using the service and their relatives about safeguarding procedures and what action to take if they suspected abuse.

We checked four people's care plans, to look at whether there were assessments in place in relation to any risks they may be vulnerable to, or any that they may present. Each care plan we checked contained up to date risk assessments which were detailed, and set out all the steps staff should take to ensure people's safety. People's daily notes, where staff recorded details of the support and care provided to people, showed that staff were acting in accordance with people's risk assessments.

We checked the systems the provider had for monitoring and reviewing safeguarding concerns, accidents, incidents and injuries. We saw that a member of the provider's management team carried out a regular quality audit of the home, and part of this audit included checking whether there had been any safeguarding referrals or accidents and incidents. The registered manager also maintained a central file of safeguarding, where any incidents were monitored and records kept of referrals to the local authority and notifications to the Care Quality Commission. We cross checked this with information submitted to the Commission by the provider, and saw that all notifiable incidents had been alerted to CQC, as required by law.

Recruitment procedures at the home had been designed to ensure that people were kept safe. Policy records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees.

We checked the arrangements in place to ensure that people's medicines were safely managed, and our observations showed that these arrangements were predominantly appropriate although we identified a small number of shortfalls. Medication was securely stored, although there were no arrangements in place

for recording the temperature that non-refrigerated medication was stored at. We checked records of medication administration and saw that these were appropriately kept. There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy.

Some people were prescribed 'when required' medicines, often referred to as PRN. However, we found there was little evidence of PRN protocols being used, which is where staff would access information about the symptoms or signs people would display that indicated that PRN medication should be administered. In addition, we found staff did not record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. We discussed this with the registered manager and they implemented a PRN protocol system immediately after the inspection and supplied CQC with written confirmation that this had been put in place.

## Is the service effective?

### Our findings

We asked three people using the service about the food available. They were all positive about their experience of food and mealtimes. One person said: "The food's always nice, nothing to grumble about here." Another said: "Always pleasant and always plenty of it." People we spoke with told us that there were choices available at mealtimes, and our observations reflected this.

We observed a mealtime taking place in the home, and saw that it was a relaxed and pleasant experience. Tables were well laid out, and people had a choice of eating in the dining room, in the lounge or in their own rooms. We saw that staff supported people to ensure their preference was upheld. Where people needed assistance during the mealtime staff provided it in a discreet and gently manner

We checked four people's care records to look at information about their dietary needs and food preferences. Each file contained up to date details, including screening and monitoring records to prevent or manage the risk of poor diets or malnutrition. However, we identified that the provider was not always meeting one person's needs in relation to their dietary requirements. The person's GP had advised the home that a specific food group should be excluded from the person's diet in order to improve their health as an allergy was suspected. We noted that although the provider was taking some steps in relation to this, other meals included the food group that was suspected to be allergy inducing. We discussed this with the registered manager on the day of the inspection, and they told us they would be carrying out an immediate review of this.

We looked at the arrangements in place for complying with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

Some of the care plans we looked at showed that the person concerned lacked the mental capacity to consent to their care and support. Where people lack capacity, decisions that are made on their behalf should be made in the person's best interests, and people who know the person well should be consulted for their views about the decision. We found that the provider could not evidence that they had done this. Where people had the capacity to consent to their care, there was little evidence that the provider had sought their informed consent. For example, one person's file clearly stated that they had the mental capacity to give consent to their care and treatment, but there was no record within their file of this being sought. Another person's file showed that the provider had been authorised to deprive them of their liberty, in accordance with the MCA, indicating that they lacked capacity. However, where decisions had been made about how to care for the person, for example within care plans or risk assessments, there was no evidence that relevant people had been consulted to ensure the decisions were in the person's best interests.

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

## Is the service caring?

### Our findings

We carried out observations of staff interactions with people using the service over the course of the inspection. Staff were reassuring and showed kindness towards people both when they were providing support, and in day to day conversations and activities. Staff we spoke with told us that treating people with dignity and respect was important to them, and felt it was the most important part of their work. The atmosphere within the home was friendly and relaxed, and the approach adopted by staff contributed to this.

We undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. By using SOFI we saw that people experienced care and support delivered in a kind and patient way, and saw that when staff spoke with people it was with warmth. People experienced staff chatting to them in passing as well as in a focussed support environment.

The home had an initiative called "Quality Time." This is a half hour period during in which everyone working in the home, including ancillary and administrative staff, are required to sit and chat with people using the service. We observed this and saw that people were having constructive and meaningful conversations with staff, and it promoted a collaborative atmosphere in the home.

There was a programme underway in the home to re-model the environment to be more dementia friendly. This included new floor surfaces and brightly painted doors, to enable people with cognitive impairment to orient more easily.

We looked at feedback the provider had received from cards and letters provided by people's relatives, and saw that care was often praised. One relative wrote: "Nothing was too much trouble." Another wrote: "The staff went out of their way to keep us informed."

We checked four people's care plans, and saw that risk assessments and care plans described how people should be supported in a way that meant their privacy and dignity was upheld. We cross checked this with daily notes, where staff had recorded how they had provided support. The daily notes showed that staff were providing care and support in accordance with the way set out in people's care plans and risk assessments.

## Is the service responsive?

### Our findings

The home had a dedicated activities coordinator who devised a programme of activities within the home. During the inspection a quiz was taking place, and records showed that other activities included floristry, reminiscence games and visits from external entertainers. People we spoke with said that they could get involved in activities if they wished to, and told us there were varied things to do.

We checked care records belonging to four people who were using the service at the time of the inspection. We found that care plans were detailed, setting out exactly how to support each person so that their individual needs were met. They told staff how to support and care for people to ensure that they received care in the way they had been assessed. Care plans were regularly assessed to ensure that they continued to describe the way people should be supported, and reflect their changing needs.

We looked at evidence within some of the care records we checked which showed that people had required the input of external healthcare professionals. Where this was needed the provider made prompt referrals, and where guidance had been provided this was being adhered to.

Each person's care records included a range of screening tools, such as charts where staff were required to monitor the person's risk of poor skin integrity or malnutrition. We noted that these had not always been completed regularly, meaning that there was a risk the provider may not recognise and respond to changes in people's health or wellbeing. We discussed this with the registered manager and a member of the senior management team on the day of the inspection. They described that the use of these tools was relatively new, which corresponded with what we saw, and that staff were being trained and prompted to ensure they were completed thoroughly.

There was information about how to make complaints available in the guide provided to people using the service, and in the provider's Statement of Purpose. However, we noted that it did not direct complainants to the correct resource if they were seeking external remedy to their complaint. The provider contacted the Commission in writing shortly after the inspection to confirm and evidence that this information had been rectified. Where complaints had been received, they had been responded to within the timescale set out in the provider's complaints policy.

## Is the service well-led?

### Our findings

The service had a registered manager, as required by a condition of its registration. Staff we spoke with told us they found the manager to be accessible and supportive. The registered manager was supported by an operations manager who attended for part of the inspection. Both the registered manager and the operations manager knew the service well, and were leading a programme of improvements within the home, some of which we saw during the inspection.

We asked two members of staff about the arrangements for supervision and appraisal. They told us that they received regular supervision and annual appraisal. We checked the supervision schedule and records of supervision which showed that staff received a formal, documented supervision with a manager approximately every six months.. Supervision and appraisal records showed that staff development, training and people's support and care needs were discussed, to enable staff to carry out their roles well and meet people's needs.

Team meetings took place regularly, and were used by members of the management team to inform staff about developments and changes in the home, as well as to discuss standards and targets for improvement.

There was a system in place to audit the quality of the service. This was carried out by a senior manager within the company. We looked at this and found it was a detailed and thorough audit, which checked all aspects of the service being provided. The audit document included an action plan where issues were identified, and we saw evidence that actions had been undertaken. However, the registered manager and senior manager both acknowledged that the audit had failed to identify the shortfalls we noted in relation to complying with the Mental Capacity Act 2005. They said that this would be rectified so that future audits looked at this.

We asked to see a copy of the service's Statement of Purpose. A Statement of Purpose is a document that registered providers are required by law to have, and to keep regularly under review. This document had been updated recently, but the provider had not notified CQC of this update, which they are required to do. We also noted some incorrect information in it. Shortly after the inspection the provider submitted a notification to CQC and a new Statement of Purpose with the incorrect information corrected.

It is a requirement that providers display their CQC ratings prominently both within the service and, if relevant, on their websites. We noted that although CQC ratings were displayed within the home, the provider's website contained a link to their report on CQC's website but did not display their rating." We raised this during the inspection with a member of the provider's senior management team. They told us that this would be addressed immediately. However, two weeks after the inspection the provider was still failing to display their ratings on their website.

This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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  The provider was failing to act in accordance with the Mental Capacity Act 2005 in relation to obtaining people's consent to care, and in relation to how to act when people did not have the capacity to consent to their care.