Mr Roger Daniel

Red Rose Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 1 and 2 November 2016. Red Rose Nursing Home is registered to provide accommodation for 65 people who require nursing or personal care. There were 59 people living at the service at the time of our inspection.

Red Rose Nursing Home is situated in Farndon in Nottinghamshire. The service is split into three distinct units each with communal living spaces; Memory, Willow and Castle. People living in Willow and Memory are supported by a team of nurses and care staff. People living in Willow primarily have complex health needs, whilst people living in Memory have dementia related needs. In Castle people who require support are supported by a team of care staff.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our visit to Red Rose Nursing Home we found that people were not always protected from the risks associated with their care and support. Action was not taken to protect people from the risk of improper treatment.

There were enough staff to provide care and support to people and safe recruitment practices were followed. People received their medicines as prescribed.

People were supported by staff who received training, supervision and support.

People's rights under the Mental Capacity Act (2005) were not always respected. However, where people had capacity they were enabled to make decisions about their care and support.

People were supported to eat and drink enough, had access to healthcare and their health needs were monitored and responded to.

Staff were kind and compassionate. People were treated with dignity and had their right to privacy respected. Staff understood how people communicated and people were provided with information in a way that was accessible to them.

People were at risk of receiving inconsistent support as staff did not always have access to information inform support. People were provided with the opportunity to get involved activities but many people lacked meaningful occupation.

People were supported to maintain relationships with family and friends and visitors were welcomed into the home. People and their families were involved in planning their care and support. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

The registered manager was passionate about their role and the service, kept up to date with good practice and was involved in innovative projects. People and staff were provided with opportunities to give their views on how the service was run. There were systems in place to audit the quality of the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to protecting services users from abuse and improper treatment. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Action was not taken to protect people from the risk of improper treatment.

People were not always protected from the risks associated with their care and support.

There were enough staff to provide care and support to people and safe recruitment practices were followed.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who received training, supervision and support.

People's rights under the Mental Capacity Act (2005) were not always respected. Where people had capacity they were enabled to make decisions about their care and support.

People were supported to eat and drink enough. People had access to healthcare and their health needs were monitored and responded to.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate. People were treated with dignity and had their right to privacy respected.

Staff understood how people communicated and people were provided with information in a way that was accessible to them.

People were involved making decisions relating to their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent support as staff did not always have access to information about the support they required.

People were provided with the opportunity to get involved in activities but many people lacked meaningful occupation.

People were supported to maintain relationships with family and friends and there were systems in place to deal with complaints.

Is the service well-led?

Good

The service was well led.

People and staff were provided with opportunities to give their views on how the service was run.

There were systems in place to audit the quality of the service.

The registered manager kept up to date with good practice and was involved in innovative projects.

Red Rose Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This inspection was done to look at the overall quality of the service and to explore information received since our last inspection.

We inspected Red Rose Nursing Home on 1 and 2 November 2016. This was an unannounced comprehensive inspection. The inspection team consisted of two inspectors 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views. Before 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.

During our visit we spoke with six people who used the service and the relatives of seven people. We also spoke with four members of care staff, two nurses, a student undertaking work experience, the deputy manager, the registered manager and the chief operating officer. We looked at the care records of 11 people who used the service, medicine administration records, staff training records and four staff files, as well as a range of records relating to the running of the service.

We observed care and support in communal areas. 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.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm. We saw that some people communicated through behaviour which put others at risk. One person in particular had hit other people who used the service on a number of occasions, with a high number of these being directed at two other people who used the service. The person had a care plan in place for their behaviour which asked that staff divert the person if they displayed behaviour which challenged and stated, 'staff to be aware of [name]'s location at all times'. However the care plan did not detail the history of this person hitting the other two people or the risks this posed to them. During our inspection we observed these three people were sitting together in a small lounge which was, for the most part unsupervised by staff. We spoke with the registered manager about this and they told us that staff tried to keep the three people separate; however this was not the case during the first day we visited. Records of incidents showed that staff had not always implemented the guidance in the care plan which had resulted in people being hit. This meant steps were not being taken to protect these two people from the risk of harm and potential injury.

During the evening of our visit we saw the person whose behaviour put other people at risk was in another person's bedroom and the person, who was very frail, was in bed. The room was dark and the person in bed was unable to summon staff. We made sure this person was safe and reported this to the registered manager and who told us there was nothing that could be done to prevent the person entering other people's bedrooms and that 30 minute checks were in place to make sure this person was checked frequently. We made a referral to the local authority safeguarding adult's team as we felt the person in bed had been placed at risk of harm and that there was a risk this could happen again.

There were care plans in place which detailed how staff should support people whose behaviour could present challenges. Staff recorded the behavioural incidents in relation to what had happened. However in a high number of cases, staff had left the 'action taken' box blank which meant it was unclear how the incident had been managed. Additionally there was no follow up or analysis of these incidents to identify what had triggered the incident and to ensure action was taken to reduce the risk of a similar incident occurring.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the registered manager informed us that they were exploring the possibility of additional funding for one person to safeguard the welfare of others in the service.

In spite of the above, people who used the service told us that they felt safe. One person told us, "I have never felt frightened, I have always felt safe." We spoke with another person about whether they felt safe and they told us, "Yes I do". The relative of a person who used the service told us, "[Relation] is absolutely safe; the staff always know where they are. They are much more settled and relaxed here (than previous home)".

Staff we spoke with had a good knowledge of how to recognise different forms of abuse and understood

their role in reporting any concerns or allegations to the registered manager. One member of staff told us, "Safeguarding is everyone's responsibility." Another member of staff said, "If I saw something that wasn't right I would pull [staff] up on it and report it". Staff were confident that any concerns they raised with the management team would be dealt with properly.

Prior to and during our inspection we received information of concern about inappropriate moving and handling techniques used by some staff. During our visit we also observed an incident of staff using unsafe moving and handling techniques. We immediately reported this to the registered manager who took decisive action and shared the information with the local authority safeguarding adult's team.

In contrast, we saw other people being supported to move and transfer by staff who were knowledgeable, kind and compassionate. For example, in one area of the home we saw staff supporting one person to move using a standing hoist, staff quickly identified that the person did not feel comfortable with this. They provided the person with reassurance and successfully supported them using alternative equipment. It was clear that the person felt comfortable and safe in their presence.

People were not always protected from the risks associated with their care and support. For example, one person had been assessed as being at risk of choking. Care records showed that the person's GP had advised that their drinks should be thickened to reduce the risk but this was not included on their care plan and the risk assessment lacked specific detail of how much the drink should be thickened. We observed the person being given a drink which was not thickened. We spoke with a staff member who told us that thickener was not needed unless the person coughed whilst drinking, however the nurse clarified that their drinks should always be thickened. This put the person at risk of choking. We shared this with the registered manager and they took immediate action to speak with staff and add the required guidance to the person's care plan. However, the following day staff had not followed the guidance and had thickened the drink to the incorrect consistency.

Risks in relation to the development of pressure ulcers were managed inconsistently. Some people who had been assessed as being at risk of developing a pressure ulcer had clear risk assessments and care plans in place, equipment was in use to reduce risks and records showed that these people were supported to change position regularly. A relative told us, "[Relation] has a cushion to prevent pressure sores". Another relative told us, "Staff change [relation]'s position every two hours even through the night". However, we found this was not always the case.

We observed one person on the first day we visited who was sitting in a plastic armchair with the skin of their upper legs in contact with the plastic of the chair. The person's care plan and records showed they had previously developed blisters on their upper legs. The tissue viability nurse had deemed the chair as unsuitable and had recommended an alternative chair and bed rest to assist healing and reduce the risk of further blisters. Our observations and records showed that these measures were not in place. Although the person was taken to their bedroom in the afternoon, they sat in similar plastic chair rather than given bedrest. This increased the risk of them sustaining skin damage. We shared this with the registered manager who, following our visit, informed us that they had spoken with a specialist health professional regarding this and were working towards a solution.

There were effective systems in place to support people who were at risk of falling. When people had been assessed as being at risk of falling there was evidence that different options had been considered to reduce this risk and appropriate preventative measures were in place. People's relatives told us that they felt people were protected from the risk of falls. One relative said, "[Relation] is at risk of falls and there is a checking system in place". One person had sustained a fall and we saw there was a post falls pathway used to

monitor the person and ensure they received health care assistance. This had been effective identifying an injuries and enabling the person to access appropriate support. Patterns of falls were analysed and action was taken to reduce the likelihood of future incidents.

There was a contingency plan in place, to ensure continuity of care in emergency situations that might disrupt the service. This listed emergency contacts and evacuation plans. Records showed that a fire safety risk assessment had been completed and we also saw records of regular checks carried out on fire doors and emergency lighting to ensure they were in working order.

People living the home gave mixed feedback about staffing levels. One person told us, "I don't have to wait when I press my buzzer." A relative of someone living at the service told us, "The staffing levels are good and there is always a nurse and senior staff as well as more junior staff". Another relative said, "There are always staff around". However other people told us that they felt there were not sufficient numbers of staff. One person told us, "They could do with more staff". A relative of someone using the service said, "There aren't really enough staff, (although) the staff do answer the buzzers as soon as they can."

During our inspection we observed that there were enough staff present to meet people's needs and people were assisted in a timely manner. The registered manager told us that they had flexibility in their staffing levels and could increase this based upon the number of people using the service and the complexity of their support needs. The staff we spoke with told us that staffing levels were normally sufficient although stated there had been times recently where staffing levels had dropped below the number determined by the provider, however staff told us that the team normally "pulled together" to cover sickness and other unplanned leave.

People could be assured that safe recruitment practices were followed. The service had taken the necessary steps to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. Proof of ID and appropriate references had been obtained prior to employment and were retained in staff files. Where people had submitted a CV with their application the reason for leaving employment had not always been stated which meant that it was not clear if the person had been dismissed from previous employment. We discussed this with the registered manager who told us that they would ensure that this was addressed in the future.

People were given their medicines as prescribed. Medicines records were completed accurately to show when people had been given their medicines. Each person had a medication sheet which included a photo of the person, allergies and the person's preferences for taking medicines. There were clear protocols in place for 'as required' medications which contained detailed information about when these medicines should be given.

Medicines were stored safely in a locked trolley which was kept in a locked room. Staff regularly checked the temperature that medicines were stored at and we saw that the temperatures were within an acceptable range. Controlled drugs were safely stored. Staff had been trained in the safe handling and administration of medicines and had their competency assessed annually to make sure they were keeping up to date with good practice. We observed a nurse administering medicines and saw that they followed safe practice. Medicines audits were carried out monthly to ensure medicines were being managed safely.

Good

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

The management team and staff had a good understanding of the MCA and most people had detailed MCA assessments in place. However, we found that the MCA was not being applied consistently. For example, the care plans of two people who did not have the capacity to consent to bedrails did not have MCA assessments in place relating to this decision. We looked at the care plan of another person who lacked capacity to make certain decisions and who received their medicines in their food without their knowledge, called covert medicines. Their care plan did not contain evidence that this decision was made in their best interests.

We shared this feedback with the management team and they were proactive in taking action to ensure that people's rights under the MCA were protected. Following our inspection the registered manager informed us that they had put detailed MCA assessments in place as required.

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). The management team had an understanding of DoLS and had made appropriate applications to the local authority. When DoLS had been granted where recommendations had been made these had been acted upon.

Where people had capacity they were supported with decision making and we observed that staff spoke with people and gained their consent before providing support or assistance. People told us that they felt in control of their care. A relative of a person who used the service told us, "[Name] has freedom to make choices." Another person's relative told us, "[Relation] can make choices." In contrast to this we observed one member of staff making choices on behalf of people without making any effort to involve them in the decision; we raised this with the registered manager who assured us that this was an isolated incident and would be dealt with on an individual level with the staff member.

People and their families told us that they felt that staff were well trained and had the skills required to do their job effectively. One person told us, "The staff are nice and they know what they are doing". Another person commented, "The staff are well trained". A relative of someone who used the service told us, "Staff are effective as the nurse is always there and they are trained in mental health". Another relative told us, "Here the staff are experienced, they are trained".

People were supported by staff who had received appropriate training. Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. One member of staff

told us, "We get lots of training." We saw records which showed that staff had up to date training in areas determined by the provider as compulsory including safeguarding, the MCA, equality and diversity and moving and handling. Some staff also had training relating to the specific needs of people using the service such end of life care and challenging behaviour. The registered manager told us that staff received 'mattering' training which focused on ensuring that people who are living with dementia feel that they matter to others.

The registered manager informed us that nurses were able to keep up to date with best practice by attendance at updates provided by the community matron. Nurses received regular medicines training and records showed that they had their competency to administer medication checked annually.

Staff were provided with an induction when starting work at the service. The registered manager told us that, "We try to support staff with a really thorough induction." They went on to tell us that staff completed training during this period and spent time shadowing more experienced staff members and reading care plans. Staff feedback about this was varied, one member of staff told us their induction was very limited and they were expected to provide support to people after just two days of shadowing other staff. In contrast another staff member told us that they had a full induction and felt competent to support people following their induction.

New staff had completed, or were in the process of completing the Care Certificate. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. A number of staff members had also recently been trained as Care Certificate mentors to support new staff through this process.

People were supported by staff who received supervision and support. Staff we spoke with told us that they felt supported and they had had recent supervision meetings. One member of staff told us, "Yes we have supervision, it's useful, we talk about how you are getting on, any training you need. I think they happen every couple of months". The registered manager and clinical lead undertook professional supervision for the nursing team. We saw records which confirmed this to be the case.

When people required specialist diets these were provided and the kitchen staff had clear information about people's dietary needs. However, we observed that the options provided for people who required a soft or blended diet appeared unappetising. We also received feedback during our visit that the quality of these meals was poor and there was little variety. We shared this feedback with the registered manager who, following our visit, informed us that this had been discussed with the kitchen team and they were in the process of exploring alternative options for people receiving special diets.

People were supported to eat and drink enough. Generally the people we spoke with were positive about the quality and quantity of food on offer. One person told us, "The food is very good, there is enough to eat and drink". One person's relative shared their observation that, "The food is fabulous." We saw that people were offered a choice of food and there were snacks and drinks available throughout the day. People were given kind and compassionate support at lunchtime where needed and were assisted at their own pace.

People told us their choices about food and mealtimes were respected. One person said, "I could have a different meal if I wanted to." We observed one person who decided they did not want their chosen meal; staff respected this and quickly provided an alternative. When people chose to stay in their room, food was taken to them and they were provided with assistance as required.

There were effective systems and processes in place to protect people from the risk of weight loss. The

registered manager told us in the PIR that they had systems in place to identify weight loss and ensure appropriate support was provided to people to maintain a healthy weight. People's care plans detailed what support they needed with nutrition and people's weight and BMI were assessed regularly. We saw that where changes or concerns were noted action was taken. For example one person's weight had decreased, this had been identified and the staff team were monitoring the person's weight and food intake and had contacted the GP to request specialist support.

People were supported with their healthcare needs. Staff we spoke with had a good knowledge of people's health related needs. Records showed that people were supported to access their GP as needed as well as other health professionals such as dentists and opticians. People were also supported to attend hospital appointments and the outcomes of appointments were recorded. The registered manager told us in the PIR that they worked closely with a range of healthcare professionals to ensure people's healthcare needs were met. This was supported by records which showed that people had access to a range of health professionals including tissue viability nurses, diabetic nurses, and palliative care specialists. A relative of someone who used the service told us, "Health needs are always picked up and the doctor called."

People received effective healthcare from the nursing team at Red Rose Nursing Home. For example, where people required support with the care of wounds and pressure areas there were effective systems and processes in place to ensure that people received support from the nursing team to facilitate healing and prevent further skin breakdown. We talked with one nurse who spoke with pride about their approach to wound and pressure area care, they told us, "We grasp the problem and it doesn't take us long to get them (wounds) healed". A family member of someone who used the service told us, "The health care is good".

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring. During our visit we saw positive interactions between staff and people who used the service. People we spoke with were positive about the staff team and the support they received. One person told us, "The staff are all very kind." Other people we spoke with used words such as, "Marvellous", "Lovely" and "Super" to describe the staff team.

We observed respectful relationships between staff and people who used the service. Staff had knowledge of people's support needs and their likes and dislikes. The relative of a person who used the service told us, "Staff know [relation] well and they know what matters to them.". The relative of another person who had lived at Red Rose Nursing Home for some time praised the staff and explained, "It's as if staff have grown with them".

Staff responded to people when they became distressed and offered comfort and reassurance. The relatives of people using the service felt that people were responded to quickly when they became upset. One relative told us, "Staff are supportive to [relation] when they become upset." Another family member told us, "The staff are trained and do talk to [relation] to calm them down."

People's rooms were personalised to their preferences and had a homely feel. Many people had memory boxes outside their bedroom doors which contained photos and personal items that signified something of importance to them. Most people's care plans contained information about the individual preferences, interests and people's personal history. However, this was not always the case in one area of the home we observed that many care plans lacked this individualised information. We discussed this with the registered manager who was aware of this and explained that gathering this information was a challenge due to the fast paced complex nature of the service provided in this part of the home.

People were supported to retain their independence. The registered manager told us in the PIR, "Where possible residents are encouraged to maintain skills with domestic tasks that they may enjoy, such as gardening or small household tasks". There was information in people's care plans about what people were able to do for themselves and areas in which they needed prompting or assistance.

Staff had an understanding of people's communication needs and tailored their support accordingly. There was information in people's care plans about how people communicated and how staff should communicate with them. We observed that pictorial menus were available and signs and symbols books were located throughout the building for staff to use to support communication. We heard staff providing explanations to people using language that was appropriate to the person and saw that staff tailored their communication style to individual need. We spoke with the relative of someone who lived at the service who told us, "[Relation]'s eye sight is failing and they are very deaf, staff now use a whiteboard to communicate with them.".

People who used the service had access to an advocate if they wished to use one. The registered manager told us that no one was currently using an advocate to support them with decision making, but added

people had used advocates in the past. There was information displayed in the service so that people knew how to contact an advocate if they wished to. Advocates are trained professionals who support, enable and empower people to speak up.

The registered manager was passionate about ensuring that people were treated with dignity and respect. They had implemented an award system for staff who were seen to carry out an act of kindness. We saw this was being used in the service with staff being nominated for the award when positive interaction had been observed. We saw staff had received nominations for the award which stated, "The tenderness [staff member] displayed to [name] brought a tear to my eye", another nomination read, "[staff member] acted to alleviate isolation and loneliness".

The registered manager also told us in the PIR that, "We have our own dignity network where we share good practice and develop initiatives for the homes". We saw records of the dignity meetings that were attended from representatives from each service run by the provider. These meetings were used to discuss specific topics, problem solve and come up with ideas to promote dignity in care.

People's rights to privacy were respected. People and their relatives with told us that staff respected their right to privacy. A member of staff we spoke with described the actions they took to ensure people's privacy including, knocking on people's doors, covering people when supporting with personal care and the use of a sign to alert others that care was in progress. We observed that for the most part people's privacy was respected throughout our visit. Staff consistently knocked on doors before entering; they ensured that bedroom and bathroom doors were closed during personal care and we saw that people were supported to spend time alone if they wished. We did however notice that some people's curtains were left open in the early evening whilst they were in bed which meant people were able to see in to their rooms, we discussed this with the registered manager who assured us that staff would be reminded to close people's curtains.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support as care plans were not always put in place in a timely manner. We spoke with the deputy manager who told us that they aimed to develop a basic care plan within 48 hours of a person's admission. However, we found that one person who had complex support needs and who had been at the service for six days only had basic risk assessments in place. We asked staff how they knew what support to provide, they told us, "We have to rely on [name]'s relative." This meant that staff did not always have access to information about how to support people safely.

We found that whilst some care plans were detailed and clear others lacked detail and some information was missing. For example, some care plans contained in depth information about the person's life history and people's wishes for the end of their life, whereas other care plans did not have information in this area. We discussed this with the deputy manager who acknowledged this. They explained that this was a particular challenge in one unit due to the fast paced, short term nature of the service provided in this unit.

When possible people were involved in planning their own care and support and care plans were focused on people's individual needs. The relatives of people using the service were aware of care plans and told us they had been involved in developing and reviewing them. One relative told us, "I see [relation]'s care plan every six months." Another relative told us, "I have seen the care plan, it is all [relation] focused care."

Care plans were up to date and had been reviewed regularly. Staff we spoke with told us that they found care plans easy to use and they were given time to read and contribute to them. Staff we spoke with generally had a good knowledge of people's support needs and preferences and used this to inform support. People's needs were effectively communicated between staff. There were handover records in place for staff to read at the start of their shift so they would know about any changes in relation to people's care and support. These contained a good level of detail about each person and what had occurred on the previous shift.

People told us that they received the care they required and this was flexible to meet their needs and preferences. One person said, "I am helped in the way I like." Another person told us, "I could have a cup of tea at any time of day or night." A relative of someone who used the service told us, "The staff know what they are doing and they are flexible, for example if [relation] wanted a late breakfast, staff listen," Another relative told us, "Care assessments are very tuned in to dementia and Alzheimer's and staff have the skills to work with this."

We observed, and records showed, that many people lacked meaningful occupation. During our visit several people spent a significant amount of time unoccupied in communal areas or in their bedrooms and we saw that much of the communication with staff was functional and task focused. Although records showed that there were groups and events held in the service these had a limited impact on the day to day experience of people living there. Records of social activity showed that many people spent a lot of their time watching television or listening to music. One person's relative told us, "I think [relation] is probably bored", they went on to tell us, "There are no activities." Another relative told us, "They could do with more activities

coordinators." Although staff made some attempts to engage people in activity they were often interrupted by the need to provide personal care. For example, on the second day of our visit a member of staff set up a number of games and activities in a communal area, they then left the room and did not return. The equipment was not used and was packed away around an hour later.

The registered manager spoke with passion about their move away from traditional activities to "changing the moment"; they explained that this approach aimed to introduce, "small interactions that change the moment for people." We observed this in practice on two occasions and saw that this approach had a positive impact on the people involved. For example, a member of staff spontaneously started bouncing a balloon between two people who used the service. This transformed people's demeanour, both people were engaged, happy, smiling and laughing. However, this approach was not yet embedded in the culture of the service.

The service employed an activity coordinator who worked across the whole service. The activity coordinator had only been in post for a short period of time and was in the initial stages of planning events and day trips. The registered manager told us about groups and recent events that people had taken part in. There was a gardening club which was popular with many people in the home and people had grown their own vegetables in the summer. The home had also purchased electronic tablets which had been used to access dementia friendly applications and people living at the home had recently used the tablets to photograph themselves and had shared these photos with their relatives.

People were supported to maintain relationships with friends and family. People's friends and relations were welcome to visit and we saw a number of visitors on the day of our inspection. The registered manager told us, "We would only restrict visitors if the person requested it." We saw people's relatives and friends spending time with people in communal areas and making use of the facilities. One relative we spoke with said, "We can come and go as we please." The registered manager also told us that they had previously used an online service to enable people to stay in touch with their families.

People could be assured that complaints would be taken seriously and acted upon. Some people we spoke with told us they were aware of how to make a complaint and other people were reliant upon family members to raise concerns. One person told us, "I would go to the main nurse if I had any worries." People's relatives told us that they would feel comfortable and confident raising an issue or complaint with the staff team. One relative we spoke with told us, "I would first speak to the carers, then the nurse, the manager and then CQC."

Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the registered manager. Staff told us they were confident that the management team would act upon complaints appropriately. There was a complaints procedure on display in the service informing people how they should make a complaint. We saw records of complaints made in the past 12 months and we saw that they had been recorded and addressed.

We found that concerns raised by people or their families (which were not addressed as formal complaints) were not recorded which made it difficult to ascertain what action had been taken in response. One person's relative told us, "I have complained several times but I am not sure what action has been taken." We discussed this with the registered manager who informed us that action had been taken but as it had not been raised as a formal complaint this action had not been recorded.

Good

Is the service well-led?

Our findings

People spoke positively about the service they got at Red Rose Nursing Home and told us they were happy there. One person told us, "I like it very much here." Another person said, "I'm looked after well." A relative of a person who lived at the service told us, "The place feels good, it's a warm environment." The relative of another person told us, "The place is marvellous."

People who used the service and their families were supported to have a say in how the service was run in a number of ways. The registered manager told us in the PIR that they had effective systems in place to obtain and act upon people's feedback. Regular meetings were held for people using the service and their families to discuss how the service was run. Although several relatives told us the times of the meetings were not accessible to them, records showed that these meetings were well attended and used to discuss things such as activities, menus and suggestions for changes and improvement. It was clear that people felt able to express their opinion about the service in these meetings.

Relatives of people who used the service also told us that communication from the staff and management team was effective. One person said, "The communication is good". Another person commented, "I am telephoned immediately if there is a problem." Information was shared with people using the service and their relatives in an open and accessible way. The registered Manager told us in the PIR, they had developed a newsletter and we also saw information displayed around the service on notice boards.

The registered manager was committed to exploring ways to develop the service to ensure it was person centred and based upon people's individual needs. They told us about a very recently introduced change to mealtimes which aimed to challenge institutional practices and enhance people's wellbeing. Records showed that people using the service had been consulted about this change and we observed staff enabling people to give feedback on it during our visit.

Staff were given an opportunity to have a say in the service in regular staff meetings. Records of these meetings showed that they were used to discuss feedback from people who used the service, to share information and to address issues within the service. The registered manager told us in the PIR that they have, "An open door to staff, residents and relatives should they want to discuss any issues". Staff we spoke with told us they felt well supported and would feel comfortable in reporting any issues or concerns to the management team.

There was a registered manager in place who was passionate about their role. The registered manager was an experienced nurse and told us that they had an understanding of their role, felt supported by the provider and were provided with the resources required to deliver a high quality service. The chief operating officer was also present during our visit and had an in-depth understanding of the service. They were proactive in supporting the registered manager, responding to feedback and making suggestions for improvement. Staff we spoke with were positive about the management team and the support and leadership provided by them.

There was a clear management structure within the service including a deputy manager, two unit leads and a clinical lead nurse employed to oversee the day to day running of the service. We saw records of regular 'head of department meetings' which covered areas such as staffing issues, health and safety, dignity and feedback or complaints. The registered manager also told us that they had 'champions' in specific areas such as moving and handling, falls and dignity. The relatives of people who used the service told us that they felt the service was managed effectively. One relative commented, "The registered manager leads the service very well".

Although the registered manager had notified us of some events in the service, they had failed to notify us of all safeguarding incidents within the service. A notification is information about important events which the provider is required to send us by law. We spoke with the registered manager about this and they assured us that they were now aware of their responsibilities to notify us of these events.

The management team at Red Rose Nursing Home spoke highly of the staff team and had found creative ways of recognising and rewarding staff who made a positive impact on the lives of people living at the service. The registered manager told us that they had a staff recognition scheme where residents and families could nominate a member of staff for good practice. We saw examples of these nominations which demonstrated that people clearly valued the support of the staff team. For example, one nomination stated, "[Staff member] is a caring person who really loves their job, this shines through in their passion and genuine interest."

We saw that the registered manager conducted a number of audits across the service such as the environment, care plans, weight charts, safety and infection control. These were reviewed monthly by the chief operating officer. Where issues were identified, actions were not always clearly recorded as having been taken. We discussed this with the registered manager who was aware of the issue and was working to improve this. Despite this, we saw that where areas for improvement had been identified action had been taken. For example, safety checks showed that water temperatures were above the recommended safe level in some parts of the home. Whilst there were no recorded actions, the registered manager informed us that maintenance had been carried out records showed that water temperatures were back within a safe range.

The provider did not have effective systems in place to observe and review the day to day culture in the service. At times we observed that in one area of the home there was a lack of oversight from the management team which impacted on the care received by people using the service. One member of staff we spoke with commented that the registered manager usually spent most of the time in their office and this view was echoed by two relatives we spoke with. We shared this feedback with the registered manager who informed us that, following our visit, they had made changes to the staff team and had also implemented regular observations and spot checks.

Accidents and incidents were analysed monthly to identify trends and to assess if any changes needed to be made. The registered manager also kept a narrative of actions taken in response to incidents. For example, one person had sustained multiples falls and we saw records to show that they had been referred to the local falls management team.

The quality of the service provided at Red Rose Nursing Home had been recognised by external agencies. The registered manager informed us that the home had the Dementia Quality Mark awarded by the local authority. This quality mark is awarded to older persons care homes in Nottinghamshire that have evidenced that they provide a high standard of care to people living with dementia. The home was also rated as a band five by the local authority which is the highest possible quality rating awarded.

The registered manager read research papers and journals and took part in local management forums to keep up to date with best practice. They explained that they seized opportunities to become involved in initiatives aimed at enhancing the quality of services provided. For example they had recently joined a national research project with Nottingham University called the National Prevalence Measurement of Quality of Care (the LPZ). This is an annual, independent measurement of care quality in the healthcare sector and focuses on pressure care, continence, nutrition, falls, restraints and pain. The registered manager explained that they hoped this would enable them to gain an understanding of what they were doing well and areas for improvement.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the behaviour of others that put them at risk of harm. Regulation 13 (1)