Roseberry Care Centres GB Limited

Harriets

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 28 and 29 July 2016 with a short visit on 2 August 2016 to give feedback to the operations manager.

We carried out an unannounced comprehensive inspection of this service on 5 and 6 January 2016, at which four breaches of legal requirements were found. This was because quality monitoring had failed to resolve issues related to good governance, staffing levels were inadequate and risk management was not appropriate. We also found that there were problems with the environment. We rated the service as Inadequate. We served the provider with a warning notice in respect of Safe Care and Treatment, Staffing and Good Governance.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches contained in these warning notices. We undertook a focused inspection on the 7 April 2016 to check that they had followed their plan and to confirm that they had started to progress the actions to meet legal requirements. We judged that by April there had been enough progress to consider the warning notice to be met but we did not amend the rating as we were unsure of how well these changes would be sustained. You can read the report from our last two inspections by selecting the 'all reports' link for 'Harriets' on our website at www.cqc.org.uk.

Harriets is a single story building situated in the village of Distington. It is registered to provide care and support to older people and people living with dementia. Accommodation is in mainly single rooms with ensuite toilet and wash hand basin. There are suitable shared areas in the home. There is a small garden area. Parking is in the public car park next to the home. The village has a regular bus service.

The home had a registered manager who had tendered her registration. A new manager had come into post and was preparing to apply for registration. 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.

People who lived in the home told us that they felt safe. Staff had a good working knowledge of how to protect vulnerable people from harm and how to report any potential safeguarding.

Staffing levels had improved but we made two recommendations about retention, deployment and competence issues in the staff team.

The service remained in breach of regulation 12 because we had evidence of failures in managing the risks related to infection control, medication, health and safety and falls.

We noted that staff had received training and were being encouraged to attend further training. No one in

the home was suitably trained to support the management of moving and handling matters. Staff supervision lacked detail and appraisal had been planned but not carried out.

This was a breach of Regulation 18 (2) because staff needed further support in order to develop in the roles.

The registered manager was aware of her responsibilities under the Mental Capacity Act 2005. We learned that people were not always asked for consent. Staff asked families about decisions without being clear on who had the legal right to support people. People were unfamiliar with the content of their care plans and were unsure of what they had consented to.

This was a breach of Regulation 11: Consent because consent was not always appropriately sought prior to care and support being given.

Good quality food was bought and suitable meals made. We saw that care files lacked detailed nutritional plans and that records of food taken by people at risk of malnourishment were not always completed with sufficient detail of food taken and had not been analysed. Some people needed more support to take a healthy diet.

This was a breach of Regulation 14: Meeting nutritional and hydration needs because not everyone was given suitable levels of support to access good nutrition.

There were problems noted both inside and outside the building. People could not safely go outside because of the lack of garden furniture, uneven paving, overgrown gardens and a missing fence next to the road. Some parts of the building needed to be more secure. Some work had been done on boilers, fire safety and sewerage. Some decoration had been completed but more work needed to be done on general standards of décor in the building. Maintenance of the environment needed to be improved on.

This was a breach of Regulation 15: Premises and equipment because the home had a number of problems related to security, maintenance and improvement.

We observed staff treating people in a caring and kind way and some people felt the staff were caring and considerate. Several people felt that staff did not spend enough time with them. Not everyone in the home was supported to be as dignified as possible. Staff tried to support people to be independent but this was not done through detailed care planning. We made a recommendation about this.

End of life care was done jointly with the local community nurses and G.Ps and was done appropriately.

We had identified issues around assessment of need and care planning when we inspected in January 2016. At this inspection we saw that some care plans had been improved but that some plans lacked detail and guidance. Staff told us that they did not have time to read the care plans. People in the home were unsure of the content.

This is a breach of Regulation 9: Person centred care because care plans did not always meet needs or preferences.

The registered manager had resigned and left the service part way through our inspection. The home had a new manager who was applying to register with the Care Quality Commission.

There had been a number of changes of manager in the last few years and this had led to some

inconsistencies and a problem in establishing a suitable culture and approach in the home that was person centred.

There was a good quality monitoring system in place but this was not being operated effectively enough to ensure that good standards of care and services were being given. Some recording was of a good standard but care records needed to be improved.

This was a breach of Regulation 17: Good governance because the established systems had not identified or managed some of the problems identified through inspection.

At the last comprehensive inspection this provider was placed into special measures by CQC. The overall rating for this service is 'Inadequate''. This inspection found that there was not enough improvement to take the provider out of special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were suitable but staff deployment needed further consideration.

Recruitment was being suitably managed.

Risks associated with health and safety, medicines and infection control had not been significantly reduced despite assessment of these problems.

Is the service effective?

Inadequate

The service was not Effective.

Staff were not receiving suitable support to develop in their roles.

Consent had not always been sought appropriately.

The environment needed to be refurbished both inside and out.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff displayed a caring attitude to people in the home.

Some of the personal care delivery did not promote dignity.

Care planning did not give staff strategies for developing independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people needed to have their care and support needs reassessed.

Care planning did not ensure that people received effective and person centred care and support.

Is the service well-led?

Inadequate

The service was not always well led.

There had been a number of changes of registered manager since the provider had taken over the home.

The service had a quality monitoring system but improvements to identified problems were not always progressed.

Harriets

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 July 2016 and was unannounced. We also went back to the home on 2 August 2016 to give feedback to the operations manager and to complete our evidence gathering.

The inspection was conducted by an adult social care inspector. On the first day of the inspection they were accompanied by 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. The expert by experience had experience of the care of older adults and of people living with dementia. On 2 August the lead inspector was accompanied by another adult social care inspector.

Prior to this visit we had gathered evidence from adult social care and health professionals. The service had been subject to a Quality Improvement action undertaken by the local authority commissioners of care. This meant that social workers, occupational therapists and some health care professionals had visited the home along with quality assurance officers from the local authority. This was done to help and support the service to improve the quality of care and services delivered. We were updated at the Quality Improvement meetings and were copied into extensive minutes. We also received sight of a quality monitoring report written by a local authority officer.

The provider had also written to us with regular updates and we were sent action plans in relation to the breaches we discovered in January 2016. We also received updates from the registered manager and the operations manager. We also reviewed the notifications of incidents in the home that the service must inform us of by law.

When we visited the home we met with all sixteen people living there. The expert by experience spoke to eleven of the service users and the inspectors spoke to some of these people and to those who were unable to speak with the expert. We also spoke with six relatives or friends. We also observed the way people

received care and support. We spoke to a visiting GP on one day and had contact with other medical professionals during the inspection.

We spoke with seven members of the care staff team, the registered manager, the new manager and the operations manager. We spoke briefly with the maintenance person and with two members of the housekeeping team. We also spoke at some length with the cook and with the administrator for the home.

We looked at ten care files and all of the medication records. We looked at six care plans in some depth. We also looked at daily notes, handover sheets, shortened versions of care needs and records of personal care and nutrition.

We also looked at six staff records. These included information about recruitment, induction, training, supervision and appraisal. We looked at the information about newer recruits and long standing members of staff. We were sent copies of the record of training received and some training courses planned for the rest of 2016.

We reviewed a number of documents related to the operation of the home. We looked at information related to quality monitoring and we received copies of the audits done by the operations manager. We received a copy of a document called "Home development plan 2016". We checked on money kept on behalf of people living in the home, the fire log record and food safety information and records of food taken.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived in the home about how safe they felt. Most people said that they had no concerns about being kept safe from harm or abuse. One person said; "The staff are really all decent people and there is nothing bad happening here. I think the people that own it would sort anything like that out." Another person told us that, "Social workers have been coming into see people who aren't capable of deciding things for themselves..." Relatives said "It seems good, never seen anything untoward" and "Never seen anything to bother us."

We had more of a mixed response in relation to staffing levels. One person said; "The staff are OK, sometimes there are enough of them and sometimes not." Another person that, "They're a bit short staffed all right, sometimes worse than others, you can wait a long time to get your buzzer answered." and another that, "They come eventually if you buzz."

A relative said told us, "It's Ok ,there always seems enough staff on when we come." Another visitor said, "There always seems plenty of staff." Other people said, "There are lots of new staff, they do try but sometimes we come in and they are all in a huddle doing paperwork and not talking to anyone or doing anything."

We spoke to staff about their understanding of safeguarding and we found that staff had good working knowledge of their responsibilities in keeping people safe. Staff had received training in relation to safeguarding and the registered manager had made suitable referrals.

We spoke to staff about their understanding of their right to voice their concerns or to report any issues. Staff had been given a confidential survey and had attended staff meetings where they could voice any concerns. They told us that they could report concerns to homes manager or the company but staff said that, at times, their concerns had not been dealt with to their satisfaction.

We had served the provider with a warning notice in January 2016 under Regulation 18: Staffing because we had judged the home was understaffed at this time. When we checked on the warning notices at our Focussed inspection in April 2016 we judged that staffing levels had improved. At this July inspection we judged that the breach had been met.

We asked for and received copies of the previous four weeks rosters for the home. The registered manager had kept us informed of staffing levels through the six month period since January. We spoke with people in the home and visiting relatives. People told us that sometimes wasn't enough staff on duty.

We checked on rosters and looked at the dependency levels of people in the service, and the tasks expected of members of staff. We judged that staffing levels were adequate to deliver care services. We did however note that the registered manager had worked as team leader for three or four days every week in the previous month. We were aware that a number of staff had left the service and recruitment was underway to the roles of team leader, senior care and care assistant. A new manager had been recruited. Housekeeping

and domestic hours were maintained despite fewer people being in residence. We judged that the home had enough staff but we considered that further work needs to be done in relation to the retention and deployment of staff.

We recommend that the provider consider the rostering, retention and deployment of staff.

We looked at recent recruitment in the service. We saw notes of interviews where the registered manager had assessed candidates' suitability. We saw well kept personnel files were in place for recruitment. New members of staff had all suitable checks in place before they had access to vulnerable adults. We judged that recruitment was managed appropriately.

We also noted that there had been some disciplinary actions taken. The registered manager had considered staff competence but we judged that further work needed to be done on this. We checked on the documentation around this and found that some files needed a little more detail to evidence the action taken.

We recommend that further work be done on managing competence in the work force and we discuss this further under Effective.

In January 2016 we served a warning notice in relation to Regulation 12: Safe care and treatment because risks associated with falls, pressure care, choking, moving and handling and admissions had not been dealt with appropriately. At a focussed inspection in April 2016 we judged that enough work had been done to begin to deal with these matters and to meet the warning notice. However at this inspection in July 2016 we found that the improvements had not been sustained in full.

In July 2016 we saw that there were a number of risk assessments on file for individual care delivery and for various activities within the home. Some of these were of a good standard. The service had an emergency plan but this needed updating as the arrangements for evacuation were those that stood when the home was part of the Southern Cross group.

We identified a number of risks around the building but not all of these had been identified in general risk assessments. We also saw some things that needed done as part of normal day to day safety measures. These included radiator covers that were coming away from the wall, 'Dorguard' fire closure devices where batteries were running out and some doors being not as secure as they should be. There were quite a lot of flies in the home when we visited and we were told that there were two fly killers that needed to be put up but had not been.

We also noted that the issues around risk in relation to falls, choking and pressure care were acknowledged but that care planning work did not always minimise these risks. We had been notified of a number of falls. These falls still exceeded the expected number for a care home of this size but had, luckily, not led to serious harm. We asked the registered manager to analyse these falls and to report back to us every month. This had happened and we had seen some reduction in the falls. We noted that further falls management needed to be put in place. We looked at falls in relation to one person and we saw that two aspects of falls management had not been worked on through care planning.

We look at medicines managed on behalf of people who lived in the home. We found that in general medicines were suitably managed with good ordering, administration and disposal of medicines. We did however note that stocks of topical creams were kept insecurely in individual rooms. In some rooms two tubes of the same ointment were open and use. In one room there were nine tubes of two different creams.

The provider had brought in a specialist company to assess the quality of infection control and they had found a number of issues. This report confirmed what we had found at our inspection visits in 2016. We saw that some of these problems were being addressed but that some of the environmental issues meant that infection control was not being managed as well as it could be. For example seals around sinks and toilets and tiles behind sinks needed to be improved but work had not commenced.

We walked around all areas of the home. We noted that bathrooms and toilets had still not been upgraded. Seals around sinks and lavatories were not completed to a good standard. some tiles were cracked. We had been told by the organisation that they would make every effort to replace wooden pipe work covers or to at least fill any gaps and paint with high-gloss paint. At this inspection visit we found that this had not been done to suitable standards to prevent problems with infection control.

We were aware that there had been a breakdown of a boiler and that this had led to a lack of hot water in one wing and in the kitchen. We learned that at some point staff in the kitchen had used hand wipes instead of washing their hands. We had asked the local authority to visit and they had advised them about improving infection control measures. The registered manager had dealt with these issues and the company had replaced the boiler. The home did not have a lead person for infection control until after an independent audit of infection control had been completed in early July 2016. The registered manager was in the process of creating a local policy and improving the information about the control of chemicals used in the home.

We saw some of the housekeeping staff working very hard to maintain and improve cleanliness and hygiene in the building. We judged that hygiene levels were of a reasonably good standard. However we did see some areas where standards needed to improve. We also heard from visitors that sometimes the environment was not as clean as it might be.

All of these issues meant that the provider was in breach of Regulation 12. Safe care and treatment. This was because risk management needed to be improved in relation to health and safety and infection control.

Inadequate

Is the service effective?

Our findings

We asked people and visitors about how effective they judged the arrangements in the home to be. We had mixed responses with some people saying, "It's gone downhill over the years. I don't need much help but I am not sure how it is for others." and a visitor said, "We are worried, it's not good and there is something wrong every time we come." Other people said, "Everything is fine here. I am Ok" and several visitors said, "We don't have any problems...seems fine to us."

Generally people were satisfied with the food provided, One person said "The food is good, you get plenty of it and you do get a choice," while another person said, "The food is OK...you don't get much choice really, it doesn't alter much." The general consensus was, as one person said, "The food is alright, it does."

People told us that they saw health professionals on a regular basis. One person said, "The nurse and the doctor come to see me and the others if we are not well."

We asked for a copy of the training matrix and the training plan for staff team. These were given to us and gave details of training received and planned. We saw that training had improved somewhat and that, in the main, staff had been given the opportunity to improve their skills and knowledge. Some training uptake was at 70% or more while other training had not been taken up by all staff. We judged that training was being encouraged and promoted. We noted however that the home still did not have anyone trained as a trainer in moving and handling. This meant that there was no one in the home trained to judge the competence of staff or to write moving and handling plans. The local authority had helped the service access suitable training and the new manager of the home was due to attend this with another member of staff.

Not all staff had received appropriate supervision at a level that would give them suitable support. The registered manager had supervised each member of the team once and some of the staff on a second occasion in the previous year. Senior staff had also recorded some supervision. One long standing staff member said they had only had one supervision in the last year. Records confirmed that supervision had not met the provider's expected levels. Some supervision notes were of a good standard while others failed to cover the developmental needs of the staff member. An appraisal system was in place but the registered manager told us that there had been no appraisals completed.

We looked at overall development of staff and found evidence to show that not all staff were being supported to develop in their role. For example when we spoke to care staff about the role of the link worker they had limited understanding of their responsibilities. Staff were not always encouraged to reflect on their practice. Supervision notes lacked evidence of in-depth discussions about improving individual team members approach to the work. Some members of staff were given tasks to complete and these were not completed. We found very little evidence of a formal approach to poor performance.

We also noted that there continued to be some issues about communication. We saw that the registered manager and the operations manager had attempted to improve communication systems with the home. This had led to supplementary daily reports, a handover record and a further 'snap shot' of the content of

the care plans. Staff said they had not read the care plans but used these notes instead. These did not give the detailed and complex guidance needed by team members that would meet individual needs in a person centred way.

This was a breach of Regulation18: Staffing because staff were not being given suitable levels of support, professional development, supervision and appraisal to enable them to carry out their duties.

The registered manager had a good understanding of her responsibilities under the Mental Capacity Act 2005. 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 in the home had been assessed for capacity and the manager had judged that some people were being deprived of their liberty. She had applied for authorities where appropriate. Some of these were now out of date and we were told that these were being reviewed.

We asked people about the way staff sought consent. Some people told us that staff did ask permission and negotiated with them about support. However we saw evidence to show that there was little guidance to counteract lack of consent for care delivery when people lacked capacity. This meant that some people were refusing personal care or were staying in bed. We judged that the team needed more guidance on the dichotomy between individual consent and the duty of care they had to vulnerable people.

We were also aware that a safeguarding referral had been made because a person had claimed to be kept in the home against their wishes. This claim had been substantiated. There had been no review of this person's placement and the staff had followed the wishes of the family members rather than the wishes of the person.

The staff team did not know whether relatives had lasting power of attorney over care and welfare. It was assumed that families would make decisions on behalf of older people. Some people told us that they wanted more control over their lives.

We asked people if they had consented to the content of their care plans. We could not find any recent written consent and did not meet anyone who knew what was in the plan. One person had a plan based on a diagnosis that was more than 15 years old. This person had not been consulted about the content of the care plan which was based on this diagnosis.

This is a breach of Regulation 11: Need for consent because care and treatment was not always provided with the consent of the relevant person.

We looked at the arrangements in place for providing food and hydration. We judged that the home ordered good quality food and that the catering arrangements were in order. Some minor changes to the menus were being planned and catering staff hoped to have more input into the menus. There was a list of special diets in the kitchen and people were in receipt of fortified foods. The cook had a good knowledge of how to help people to reduce their calorie intake.

We looked at how care staff managed the nutrition and hydration needs of people in the home. The recording of food and fluid intake still lacked detail. We could find no analysis of these records to show whether a nutritional plan was working effectively. We looked at the food intake for people who were overweight and saw that they were not following a diet that would help to reduce or maintain weight

despite the cook providing suitable alternatives. We also saw a care plan that said a person wanted to lose weight. This person said they had not agreed to this. Another person who was dependent on insulin had a dietary record that was based on carbohydrates and we could not find care planning evidence to show that the staff team had a strategy to support this person to follow a diabetic diet.

The expert by experience sat in the dining room during lunch time. Staff came in and out during this hour but there was no con-ordinated support of the people in the room. One person took 35 minutes to eat their main course but because different staff came in and out of the dining room no one noted that this person was struggling. Several people complained that they were given too much food on their plates and some people didn't finish their meals. One or two people said that the flies in the dining room put them off and they couldn't finish their food.

This was a breach of Regualtion14: Meeting nutritional and hydration needs because nutritional planning and support to eat did not always support people to have the best diet possible.

We met a local GP who said that the staff were usually quite good at communication with the surgery. We had information to show that the community nurses had not always been happy with the way staff took their advice but the registered manager had started to meet with the community nurses who said, "Things have improved but we still need to give a lot of support." We saw that staff did call out health professionals and that people could access health care support when necessary.

When we visited in January we made a compliance action about the environment. We asked that a number of issues be resolved. The provider had replaced a boiler because one wing of the home had been without heating when we visited in January. This boiler had been replaced and the heating system was working. In the six months since this visit another wing and the kitchen had been without hot water because of further failures of two other boilers. These had also been replaced.

At out visit in January 2016 we had detected a malodour in certain parts of the building. We had asked that this be investigated. We were told that there was a problem with the sewerage system. This had been resolved in the short term by the sewers being jetted. However we had also been informed by the provider that this problem might re-occur and that the pipes leading to the sewers might need to be replaced. We had not received a plan about how this matter would be resolved in the long term.

We had noted issues related to fire safety when we visited in January. Cumbria Fire and Rescue service had confirmed that there were breaches in fire safety. These had been dealt with by the provider.

Box work around some pipes had not been replaced and this continued to pose an infection control issue. Seals around lavatory pans and sinks were inadequate. In one ensuite visiting relatives had marked 'cold tap' and 'hot tap' because their relative living with dementia had been unable to determine which was which as both taps said 'cold tap'. There was minimal signage to help people who were disorientated.

The provider had closed the dementia care unit in the home and had informed relatives that this was to be refurbished. We went into this unit and found the shared areas had been painted and some signage put up. Bedrooms in this unit needed to be decorated and some needed new carpets and improvements to the ensuite facilities. Further work needed to be done to create a 'dementia friendly' environment which would meet current research into environmental standards.

Bedrooms and ensuite toilets needed to be upgraded. Some needed repairs to woodwork or plaster. One person's bed head was in the carcass of a fitted wardrobe that had been removed. Radiator covers around

the building were insecure. Some of these wooden covers had been damaged by water or other fluids. Some had sharp edges or nails sticking out of them. Some carpets needed cleaning, stretching or replacing.

When we visited in January we found that staff were using specialist equipment which belonged to the community nursing teams. Staff had used this equipment on people who had not had an assessment of need. The registered manager had dealt with this and equipment had been returned to the health service. At this visit we found two mobile hoists in an unused part of the building that had not been checked for some years. Staff did not know if these had been condemned. There was a risk of these being used with out of date safety checks.

In January 2016 we had noted that no one in the home could lock their bedrooms with a lock and key. This had not been addressed by the provider and no one could safely lock their own room. The cupboard containing chemicals was open when we went around the building and a bedroom being decorated was open leaving access to paint and tools. We had other concerns about the security of the building. Visiting relatives informed us that the door in the conservatory had been open when they started their visit. We gained access to an unused part of the building through a fire door that was wedged open. We found medicines in an unlocked cupboard in an unlocked room in this part of the building. The fence at the boundary of the property was not robust with one section of the fence missing. This could mean that vulnerable people could leave the building and end up on the A595 road.

The second day of the inspection was a warm day but no one spent time outside because paving stones were uneven and there was no patio furniture. The garden was overgrown. An outlet pipe was 'anchored' down with stones and bricks and no one could say why. Guttering needed cleaned out as weeds were growing in it. Bushes and shrubs were overgrown and flower beds needed to be weeded and planted. A relative told us, "We did some of the garden but we can't keep doing things when the company are not spending on the environment."

This was a breach of Regulation 15: Environment because the premises and equipment were not always secure or properly maintained.

Requires Improvement

Is the service caring?

Our findings

The expert by experience spent time talking with people who lived in the service and observing interactions with staff. Most people had a largely positive view of the caring attitude of staff. People told us, "They are nice the carers, they do try but they are so busy" Another person said, "It's alright here, the staff are nice to you, no problem" and another said, "The staff are OK, Sometimes there are enough and sometimes not, it's OK here"

We also had a number of people who were not very enthusiastic about the caring responses. One person told the expert by experience "They will talk to you sometimes if they are not busy but that's not often." Others said, "Some staff are better than others," "It's alright well it has to be "and "They are nice enough, they have to be." A person who was in their bedroom most of the time told our expert that staff "... just walk past me, they don't come in, just walk past me."

The expert by experience observed the support of people in bed during the visit. "I observed staff passing one person's door all day, carers entered to do various tasks but none stayed. Occasionally a carer would call out as they went by 'are you alright' but did not stop...I had to twice call staff to people who were shouting for help but not heard." Some people had their bedroom doors open as a personal preference but some doors were kept open as a monitoring approach and did not always help with privacy and dignity.

Some people would have benefitted from a more individualised approach to personal care support. Several people needed the attention of a hairdresser. Men needed shaved and some people needed help with their finger nails. Not everyone was suitably dressed. These things lessened people's dignity.

We did, however, see some very kind and caring interactions and some genuine affection between staff and people in the home. The expert by experience heard some "cheery conversations" and caring interactions. The inspector spoke with one member of the team who said, "I do my best to be as kind and as nice as I can. I treat them as I would treat my own mam and dad." We found out by talking to staff that link working was not helping staff to make supportive relationships but that staff were keen to be more involved in this role.

Although staff were quite kind to people, people's opinions and views were not sought in a robust enough way. Individual preferences were not always sought, recorded or followed. Not everyone had their care needs reviewed. Some relatives and residents meetings had been held. The operations manager had delegated this task to the management staff but it had been undertaken by the activities organiser. These had not been carried out when this person was not at work. Some of the 'This is me' documents had not been updated for a number of years and did not reflect the changes that had happened in this time. We judged that staff did try their best but that a more person centred approach would be appropriate and that this needed to be worked on by the management team.

We recommended that link working or other good practice approaches be considered and given a focus in the staff team to support the caring approach.

We saw that there had been some arrangements put into place for one person to be a little more independent. This person said they wanted to do more for themselves. We also spoke to some people who said they managed some tasks for themselves but there was evidence to show that staff had found it difficult to help these people to actually maintain good levels of independence. We did note that they had asked family members for some assistance and this had given a positive result.

We saw some evidence to show that the staff team had cared for people at the end of life in an appropriate manner. Joint working with community nurses had been in place. We saw evidence to show that discussions were underway with the local GPs and nurses to continue to improve on this. A health care provider said that they were satisfied with the end of life care. We saw some comments from families who felt people had been cared for well at this stage of life.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke to were unsure about their care plans. Some people said they had been asked about their wishes and preferences and felt that they could discuss these with staff. One person said, "I think they write something about me but I haven't read it and haven't got a copy of it." We spoke to visitors. One person said, "They have never really asked me if I have the right to make decisions for my relative but I haven't been consulted anyway."

People said that they had been quite satisfied with some of the activities on offer. Several people said, "Things haven't been so good since the activity organiser has been off...some of the staff organise things but we haven't been out much."

We reviewed a number of care files of people in the home. We looked at people with different needs and strengths. We saw that some care plans had been rewritten to a good standard but we found a number of care plans that lacked detail and guidance for staff. Staff were unsure of some changes to care delivery. We asked staff how often they read the care plans. The staff we asked said that they hadn't read many of them. One person said they read one or two every six months. Some of the newer members of staff said they "hadn't got round to reading them" and relied on other staff to tell them how to deliver care. Not all staff were able to talk informally about people's needs but some staff did show a common sense approach to care and support. People in the home were unsure if they had seen their care plans.

Reassessment of needs and strengths had not happened for some people. For example one person with a previous diagnosis had a care plan based on how they had been some fifteen years before. Some assessments failed to recognise difficulties people had in terms of psychological needs, cognitive impairment or emotional difficulty.

Some care plans lacked the detail needed to deliver consistent care for people and staff did not base their work on the content of care plans. This included the support needed for people living with dementia. Care plans for bedfast people failed to give guidance on bed exercises, meaningful activities or support to have full personal care whilst in bed.

We looked at a care plan for a person who had recently been bereaved. This was noted but there was no care plan in place to help this person with their emotional and psychological needs. This person told us they were "lost". Care plans lacked details when people had conditions like diabetes. Records showed that one person with insulin controlled diabetes had a high carbohydrate diet. Staff were unsure if this had an impact on the person's condition. Staff were unsure of the blood sugar results and did not know how to recognise a problem with blood sugar levels. The care plan lacked guidance and information.

Some of the documents we looked at simply said that people had 'refused' care and no care planning had been put in place to manage this when people lacked capacity or were unaware of their personal care needs. Staff had recorded that they had assisted people to wash but some people had no record of things like hair being washed or teeth cleaned. The home had been without a hairdresser for at least eight weeks.

Men had not been shaved. Two people had long finger nails on the first day of our inspection. These had not been dealt with by the end of the second day. A number of the women had old chipped nail varnish on their nails. No one had make-up applied and the staff were unsure of anyone having this as a preference. We sat with a person whose file said they needed full personal care support. This person had two blouses on both with food stains, unwashed hair, chipped nail varnish and long dirty nails and 'sleep' in their eyes at lunch time. The notes said that this person had been assisted to wash and dress. People at risk of falling were wearing soft slippers and staff said they 'refused' to wear supportive footwear.

Visiting professionals confirmed some of our findings shortly after our inspection and a safeguarding concern was raised about poor care planning, delivery of personal care and staff understanding of diabetes and dementia.

This is a breach of Regulation 9 Person Centred Care because care and support did not always appropriately meet people's needs or reflect their preferences.

The home employed a dedicated activities organiser. We had positive comments from families and visiting professionals about the activities on offer. We saw that there had been games and entertainments and some trips out. We met a visiting vicar who came monthly to give communion and to conduct a service. We judged that the activities organiser had really tried to offer a wide range of activities and people generally were very satisfied. The activities organiser had not been at work and activities had fallen away somewhat. Staff had made a good attempt at organising games and activities. Some people told us they did not find that the activities were to their tastes and did not join in with activities in the lounge. Some people also commented on the lack of transport available and the fact that there was no garden furniture. We judged that activities were adequate and look forward to seeing how these will develop once the lead person for activities returns to work.

The company had a suitable complaints procedure and procedure in place. We were told that there had been no formal complaints to the registered manager. We were aware of some informal complaints and a formal complaint that had gone to the company. These had been responded to in line with company policies but some of the issues were around the environment and care delivery which we also identified. These still needed to be resolved and we were aware that the provider was dealing with these concerns and complaints.

Inadequate

Is the service well-led?

Our findings

People told us that, "The manager is all right and the others in the office." Several people said that they were, "Not sure who was in charge". Some visitors said they were not happy with what they saw as lack of action on complaints, environmental improvement or care delivery. They said, "We have complained and are not happy with the responses. We haven't found the manager to be very responsive to our concerns."

The home had a registered manager who had resigned and her last day at work was 29 July 2016. The provider had already recruited a new manager who had started her induction to the home and was preparing to register with the Care Quality Commission.

We spoke to staff about the management of the service and they told us that they felt that there had been a number of changes in the home which had led to a lack of consistency. One person told us that there had been five managers in seven or eight years and that each of them had a slightly different approach to the management of the home. Staff hoped that they would have a manager who would stay with the service and help to improve the systems in the home.

We judged that these changes had led to some problems in leadership and in the culture of the service. People and their visitors had some concerns about the on-going management of the home. One person said, "The place lacks something...not sure what but I hope a new manager might lead the staff forward." We spent some time with the new manager who had some ideas about how she wanted to move the home on. Staff were hopeful that this would happen and several of them said that they would be giving the new manager a lot of support to do this.

Roseberry Care Centres GB Limited had a suitable quality assurance system in place. They had also recently employed a head of quality management who had discussed some improvements he was planning. We saw that most aspects of running a care home were covered. There were a range of documents available to help the registered manager to monitor and improve on quality.

We saw staff completing some of these check lists. Care staff spent quite a lot of time doing this. The maintenance person spent quite a lot of time on "the books". We noted that these audits did not 'capture' all of the problems we identified in care delivery or in maintenance of the home and grounds. The registered manager said that some audits "Didn't ask the right questions." We judged that the system was more than adequate to monitor and improve quality but that the audits had become a routinized task that failed to see gaps in quality.

We had evidence to show that there was a lack of analysis of the audits that were undertaken. We also judged that some recording lacked specific details. For example we could find no evidence to show that there had been an overview of the way care was delivered. Some audits showed either gaps in delivery of personal care or poor recording. We could not find evidence in the care planning system to show that these problems had been addressed by the registered manager or senior staff. Daily records did not confirm that care plans had been followed. Audits related to the environment had not highlighted all of the issues.

Identified issues were not dealt with in a timely fashion.

We also judged that although the registered manager had adjusted the care hours when resident numbers fell some work needed to be done on the deployment of staff. Not all areas of the home were orderly but the rosters showed over 30 hours a week allocated to maintenance and more than a hundred hours of domestic. The quality of care and support delivery needed to be reviewed in light of the quality standards expected by the company. The delegation of tasks during each shift did not appear to be effective.

The new operations manager who had only been in post for a few months had been spending at least two days a week in the home. We looked at the records of her visits. We noted that she had identified some of the problems we had identified. She had also devised action plans for the registered manager. Not all of these plans had been dealt with appropriately. There was also a home development plan which looked at short term improvements. Some of the outcomes to deal with issues in the environment and care delivery had dates which had been exceeded.

Some of the staff development and disciplinary work completed by the registered manager and the operations manager had been done appropriately and recorded in depth. Some issues around staff competence still needed further development and notes related to this needed more detail. Staff told us that reflecting on their practice wasn't something that they were helped with on a day to day basis. Individual staff told us that they had been encouraged to think about their practice but we couldn't see this reflected in the supervision and appraisal system. Quality monitoring had noted this gap but progress had been slow in team development. This had partly been due to staff leaving the service.

We saw a wide range of records in the service. The recording system kept by the registered manager and the administrator was in good order. The administrator could produce information quickly and the filing systems were easy to access and understand. We checked on some of the money kept on behalf of people in the service and this was in order. Staff personnel records were of a good standard and policies and procedures were easy to access.

We did, however, find that care records were not so easy to follow. Some information was recorded three times but some records also lacked detail despite duplication. Information was kept within individual files but also in handover sheets and in another document that summarised the full care plan. There was a lot of information in files which needed reviewed and some needed archived. We observed a health care professional trying to contact a relative but the contact details for this person were wrong. Staff were also unsure if this relative could make decisions about care and welfare because this information was not available to staff. Not all recording of care delivered or nourishment taken was done with the attention to detail necessary.

This was a breach of Regulation17: Good governance because the quality monitoring system was not operating effectively to promote safe care and support.

We had attended a number of quality improvement meetings arranged by Cumbria County Council. These had been started because of concerns that social workers and health care workers had raised about the service. We judged that the arrangements in place for joint working had improved somewhat over the six months since these meeting had been held. The registered manager had been meeting with the local community nurses and there was more contact with social workers and mental health workers. We had evidence to show that staff were taking the advice of people like occupational therapists and specialist nurses. We met with a health care professional during the inspection who said that joint working had improved and that the surgery had some plans to help support the staff team in a more proactive way.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care that met their assessed needs and preferences.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always asked for their consent to care and treatment. Placements in the home had not always been confirmed with the person who was in residence.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The arrangments for managing risks in relation to health and safety, medicines management and infection control failed to keep people safe.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People in the home did not always receive suitable nutrition that would meet their needs because nutritional planning was not carried through.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment needs upgrade and improved in all areas both internally and externally.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The arrangements in place for reviewing and acting upon quality matters needed to be developed.

The enforcement action we took:

Notice of proposal to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been given suitable levels of support, professional development, supervision and appraisal to enable them to carry out their duties

The enforcement action we took:

Notice of proposal to remove the location.