Mariarod Care Homes U.K. Ltd

Rosemount

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 5, 6 and 7 June 2018.

The last inspection of the service was carried out on 21 and 22 November 2017 and published on 15 February 2018. At that time the service was rated as good.

Rosemount is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Rosemount is registered to care for older people, some of whom were living with dementia. Rosemount accommodates 20 older people in one adapted building. On the days of the inspection there were 16 people living at the home.

The service has a registered manager, who is also the registered provider. 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.

Before the inspection we had received concerns relating to the health and welfare of people living at the home. On 4 June 2018, a multi-agency safeguarding meeting was held. As part of that a plan was agreed with the registered manager, health and social care professionals, to protect people's safety and wellbeing. This included health professionals visiting the home every day as part of a support and protection role. The local authority quality improvement team and community nursing team were working with the home to help support improvement. We shared our findings and concerns with the registered manager and with the safeguarding and commissioning teams during and after the inspection.

During this inspection on 5, 6 and 7 June 2018 we highlighted a number of issues that required improvement and identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found there was a lack of effective leadership and governance which impacted on people's safety, the quality of care and support people received. People did not receive safe and effective care because there were insufficient systems in place to ensure this. The checks the provider had in place to monitor the quality and consistency of the service, were not effective in identifying shortfalls and driving the required improvements.

People were not safe and were placed at risk of harm. The registered manager had failed to ensure fire safety equipment was in satisfactory order. We saw a number of fire doors were defective as they had holes in them and two powder fire extinguishers located in high risk areas, were out of date. Emergency

arrangements for actions to be taken in the event of a fire or other emergency situation placed people at risk.Since the inspection actions have been taken to address these risks.

Risks to people had not always been assessed and managed appropriately. Risk assessments were not always in place or contain enough information for staff to manage or mitigate the risk and provide safe effective care. Care plans were not always in place, completed fully or up-to-date. This meant staff did not have information on how to meet people's needs. This meant people were at risk of receiving inconsistent care and not receiving the care and support they needed.

People were not protected from the risk of harm as they were living in an environment that was not always safe. For instance, frayed carpets posed a trip hazard and people were at risk from falling from windows that did not comply with Health and Safety Executive guidance. We brought these concerns to the attention of the registered manager and they immediately arranged for them to be addressed.

People did not benefit from a clean environment. The premises were not free from offensive odours. Some carpets were stained and dirty and the home did not have adequate house-keeping arrangements.

The way the home was managed did not promote a caring ethos. People were not always treated with dignity and respect. We observed on occasions, staff would walk into a room and not acknowledge the people there. Some staff spoke in a disrespectful manner about the people they supported. For example, one staff member referred to people needing support to eat as "feeders". We observed continence products left in people's rooms which showed a lack of respect for people's dignity.

We did however see other instances of staff supporting people in a caring way. Some staff were patient with people and encouraged them to retain their independence. People were relaxed and happy in staffs' presence. Staff showed care and compassion to people and spoke about them with affection.

People did not benefit from activities or engagement that had been designed to address issues such as preventing isolation, helping to maintain the person's identity, and helping the person feel valued, helpful and involved. We saw people appeared withdrawn and disengaged with the environment. People were sat in the lounge or alone in their rooms for long periods of time just looking around or falling asleep.

People were not protected from the risks associated with the employment of staff who may be unsuitable to work with people requiring help with their care needs. This was because there was not a robust recruitment system in operation. Staff files we saw contained an incomplete employment history which had not been explored and did not always contain satisfactory evidence of conduct in previous employment, such as references.

We observed there were insufficient numbers of staff to meet the physical and social needs of people living at the home. Our observations showed there were a number of times when communal areas were left unsupervised. We saw interaction between staff and people often only happened when they needed support with a physical care task. In addition to supporting people with their physical care needs, staff were expected to prepare, cook and serve all of the food, do the laundry and attend to some cleaning around the home. This meant staff did not have time to support people in a person centred way.

People did not always receive support from staff with the knowledge and skills they needed to carry out all aspects of their roles. The registered manager had not followed their own policies to ensure staff had the necessary training to meet people's health needs.

Staff received some training which the registered manager considered essential to their roles such as, manual handling, fire safety awareness and infection control. Staff were supported by regular supervision and appraisal. Staff said they could approach the management team at any time for support and guidance.

People were not always protected from the safe management of medicines. During the inspection we observed staff administering medicine in ways that did not follow safe practice or the home's policy. Other aspects of medicine management, was safe. Medicines were stored correctly to help ensure they were safe and effective to use. Records showed medicines were given to people at the correct times.

People were seen by GPs who visited the home regularly. However, staff did not always make timely referrals to other healthcare professionals to ensure people's care and treatment remained safe or act on recommendations or instructions. Since the safeguarding process started, all relevant healthcare professionals have been involved in monitoring people's care to ensure their safety.

The home was complying with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The overall rating for this service is 'Inadequate' and the service is therefore in '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 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 registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and wellbeing were not always accurately assessed, managed or mitigated.

The provider did not ensure a safe and hazard free environment.

There were not enough staff effectively deployed to safely meet people's needs in a person centred manner.

People's medicines were not always managed safely.

People were not protected from the risks of unsuitable staff being employed to care for them, as recruitment procedures were not robust.

People were protected from the risks of abuse as staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not effective.

People's nutritional needs were not always accurately assessed and monitored.

Staff were not provided with specific training to meet the individual needs of all the people living at the home.

The premises were not suitably adapted to meet the individual needs of the people living there.

People were not always referred to healthcare professionals appropriately or promptly. Staff did not always follow guidance received from healthcare professionals.

People's rights were protected as staff followed the principles of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Inadequate

The service was not caring.

People did not always receive care and support that protected their dignity.

Staff routines took priority over the wellbeing and needs of the people who lived in the home.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not always accurate and therefore staff did not have up to date information about how to meet their needs.

People and their relatives were not always involved in developing care plans. Care plans had not always been up-dated when people's needs had changed.

People didn't have meaningful activities or engagement and were not supported to live fulfilled lives.

There was a complaints procedure in place and people told us they knew who to speak to about any concerns.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective leadership and governance which impacted on the quality of care and support people received.

There were insufficient systems in place to ensure that people received safe and effective care.

The provider did not have adequate systems or resources in place to assess, monitor and improve the quality and safety of services provided.

People, their relatives and staff found the registered manager friendly and approachable.

Staff told us they felt well supported by the registered manager.

Rosemount

Detailed findings

Background to this inspection

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

Before the inspection CQC was made aware of an incident where one person did not receive appropriate medical support in a timely manner. This incident was subject to a safeguarding enquiry and we did not look at the specific event during this inspection. We were also made aware of concerns about the care of two people who were also subject to individual safeguarding enquiries. We looked into general concerns raised by health professionals about the care and treatment of people living at Rosemount.

This inspection took place on 5, 6 and 7 June 2018 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

Before visiting the home we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. We reviewed information shared with us from the adult safeguarding team, local authority, quality and improvement team and the community nursing team. During the inspection we spoke with three visiting health care professionals. This enabled us to ensure we were addressing potential areas of concern.

Not everyone living at Rosemount was able to tell us about their experiences due to cognitive impairments so we used the short observational framework for inspection (SOFI). SOFI is a tool developed and used by CQC inspectors to capture the experiences of people who use services who may not be able to express their views for themselves.

We used pathway tracking to follow people's care through from its planning to its delivery. As part of this we looked at seven people's care plans and daily records, people's medication administration records and a range of other records relating to people's care such as food and fluid charts, bowel charts and repositioning charts. We looked at three staff recruitment files, an overview of the training and supervision for staff and

other records relating to the running of the home such as quality assurance documentation and policies and procedures.

We met with all of the people living at the home. We spoke with eight people, with one relative and nine staff including the registered manager, assistant manager, admin assistant and six care workers. We looked around the home and observed care, checked medication rounds and observed lunch and other social activities.

Inadequate

Is the service safe?

Our findings

People were not safe and were placed at risk of harm. Risks to people's health were not managed; the environment was not safe; there were not always sufficient or competent staff on duty to meet people's needs; and staff recruitment was not robust. The local authority safeguarding team shared concerns with us about the safety of people before our inspection.

People were at risk because the registered manager had failed to ensure fire safety equipment was in satisfactory order. When we walked around the home, we noted a number of fire doors were defective as they had holes in them. This would significantly reduce its resistance to the effects of fire or smoke as their integrity had been compromised. We saw two powder fire extinguishers located in high risk areas (the laundry and kitchen) were out of date. All portable fire extinguishers require periodic inspection, maintenance and testing. The label on the fire extinguisher in the laundry stated it was last tested in September 2015 and someone had written in black pen, 'do not use out of order'. The label on the fire extinguisher in the kitchen said 'do not use, low pressure, condemned'.

We brought this to the immediate attention of the registered manager. They told us they had received two replacement fire extinguishers and they were in a box next to the entrance. The despatch note said they had been sent to the customer on 1 December 2017. The registered manager did not think they had been at the premises for that length of time but could not tell us when they thought they had been delivered.

Records showed that routine checks on fire and premises safety had been completed by the home. The staff member responsible for checking the homes' fire safety provision said they visually checked fire extinguishers monthly to see if they were intact but did not check servicing dates. The registered manager told us they did not have a policy or procedure in place for checking fire safety.

Arrangements for actions to be taken in the event of a fire or other emergency situation placed people at risk. For example, one person recently admitted to the home, was given a room on the first floor of the building. People accessed the first floor with the aid of a stair lift as the home did not have a passenger lift. The person required the assistance of two carers and a lifting hoist to move. The home had two fire evacuation chairs to evacuate people who were immobile. The evacuation chair had an upper weight limit of 100kg. One person possibly weighed more than this, but had not been weighed. There was no personal evacuation emergency plan (PEEP) in their records. This meant staff did not have guidance on how they could safely evacuate this person in an emergency and could not be certain the equipment available to them was safe to use. The purpose of a PEEP is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. The PEEP should be available at all times so that attending fire crews have access to this information.

Since our inspection one person at risk has left the home and the fire authority have visited the home.

People were not protected from the risk of harm as they were living in an environment that was not always safe. On the first day of the inspection we saw the carpet in the main hall between the communal area and

resident's toilet was a potential trip hazard for people as it was frayed and lifting away from the floor. Windows on the ground floor and three windows on the first floor of the home did not have restrictors which complied with Health and Safety Executive guidance. Risk assessments in relation to the use of window restrictors had not been carried out as they should be. This meant the registered manager did not always ensure risks to people posed by the building were minimised.

We brought this to the attention of the registered manager who told us they were aware of the frayed carpet but had not taken any action to address the hazard. They were unaware of the necessity to risk assess the use of window restrictors. The registered manager immediately arranged for the carpet to be replaced and widow restrictors to be fitted to the windows.

Risks to people had not always been assessed and managed appropriately. For example, one person was admitted to the home on the 6 April 2018. We saw that potential risks to the person such as; the risk of developing pressure ulcers, risks associated with moving around the home and risks of malnutrition had not been assessed. There were no care plans in place for any aspect of the person's care. This meant the person was placed at risk due to the lack of information in their records.

Assessment tools were in place to assess whether people living in the home were at risk of malnutrition. However, they had not always been completed or used correctly and consequently some of the assessments were incorrect. For example, one person's nutrition screening assessment scored zero each month from January 2018 to May 2018, meaning the person was at low risk of malnutrition. This assessment was based on factors such as food intake, weight loss and BMI. The nutrition care plan instructed staff to weigh the person monthly. The person's weight record charts show they had not been weighed in the months January to May 2018. This meant no monitoring of the person's weight was taking place so that the level of risk could not have been adequately assessed.

Two people were at risk of choking due to swallowing difficulties. There were no choking assessments in place for either person to highlight the risks and the actions that should be taken to prevent this happening. This meant there was a risk staff may not know what actions to take should the person require urgent support when choking. Staff told us one person was taking a soft diet and were having their fluids thickened with two to three scoops of thickening granules. We asked them to show us where this information was held. The staff member took us to an open tub of thickening granules in the kitchen and started to read the instructions on the side. There was no individual information from the speech and language therapist (SALT) about this person's diet and fluids for staff to refer to in the food preparation area or in their care records. This was also the case for the other person on soft diet and thickened fluids.

Since our inspection a speech and language therapist has visited the home to carry out assessments and has put in place appropriate management plans. The district nursing service is visiting on a daily basis to oversee that these plans are being implemented.

During the inspection we observed staff assisting people to eat. We found that staff did not always demonstrate safe practice. For example, one staff member was helping the person eat their meal. They did not sit next to the person, but stood over them. They did not ensure they were giving the person appropriately sized mouthfuls and did not wait until the person had swallowed this safely before they gave them more to eat. This put the person at risk of choking. Staff did not always demonstrate full understanding of this risk and how to manage it. Staff told us they had not received training in supporting people with swallowing difficulties.

Some people were identified to be at risk from pressure ulcers and were provided with pressure relieving air

flow mattresses. One person's risk assessment identified they had a very high risk of pressure damage and a pressure relieving mattress was in place to prevent this. The air mattress was required to be set according to the person's weight. The mattress was set for a person weighing 115kg. However, the person had not been weighed and this setting was based on a visual estimate. Their risk assessment did not guide staff on what action they needed to take to mitigate or manage the risk. There was no skin care plan. This placed the person at potential risk of skin damage.

Records did not always contain details on how to meet people's specific medical needs. For example, one person was an insulin dependent diabetic. There was no care plan or risk assessment in place to support staff to deliver effective diabetes care. There was no guidance on how staff should manage and monitor this person's diabetes or what action they should take if their blood glucose was too high or too low. There was no information about dietary needs or regular diabetic checks, such as specialist foot and eye care services. The staff were not following published national guidance in relation to diabetes by creating a person centred care plan on the management of the condition. We spoke to staff who had limited knowledge of the condition. This meant staff may not know how to meet the person's needs or how to support them if they were unwell.

Risks associated with people's continence needs were not being managed. One person was admitted to the home with a urinary catheter. There was no care plan regarding catheter care and no risk assessment had taken place. This meant that staff did not have the necessary information to manage the risk and care for this person safely. Staff told us when the person was admitted to the home they were not given any information about caring for a person with a urinary catheter and were not aware of the potential risks to the person. Staff we spoke with told us they had not received any training or information about catheter management.

As part of assessing people's continence needs, staff were monitoring people's bowel motions to ensure people were not at risk from constipation. Constipation reduces quality of life and can cause serious complications such as, pain delirium, urinary retention and faecal impaction. However, the risk of constipation was not being managed as staff were not acting on information recorded. For example, records showed one person had not had their bowels opened since the 22 May 2018. We saw they were prescribed medicine twice a day, to help them open their bowels. However, their medicine administration record (MAR) recorded the refusal code N, which indicated staff offered this medicine but it was not required. This person had advanced dementia and was unable to communicate verbally. There was no risk assessment or care plan in place to manage their continence needs. There was no record in the person's daily records acknowledging the person had not had their bowels opened since 22 May 2018. There was no record that the person's GP or community nurses had been informed of the lack of bowel activity. From this person's records, staff could not be sure this person had opened their bowels. Staff had failed to act appropriately to reduce the risk of complications.

People were not always protected by the safe management of medicines. During the inspection we observed staff administering medicine that did not follow safe practice in-line with the home's policy. We saw staff prepared and dispensed medicines for three people at the same time. Potting medicines for multiple people at the same time puts people at risk of receiving the wrong medicines. We spoke to the staff member who accepted that this practice was wrong.

Three people were taking blood thinning medicines. They were not always protected from the risks associated with taking those medicines. Staff were able to correctly identify and discuss the risks for one medicine but had no knowledge of the other two medicines or their risks.

The records of one person receiving a blood thinning medicine identified they were at risk of falls. Records showed they had fallen three times since January 2018, putting them at risk of bleeding. There was no risk assessment in place and staff where not aware of the risk associated with this medicine. There was no information available for staff about the person's risk of bleeding and bruising and there were no details for staff of what action to take if this happened. Staff did not have the required advice to hand to support this person and keep them safe.

All our concerns have been shared with the local safeguarding authority who have put a management plan in place which currently includes district nurses visiting the home every day. One person at risk has left the home.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other aspects of medicine management, was safe. Medicines were stored correctly to help ensure they were safe and effective to use. Records demonstrated room and medicine storage temperatures were consistently monitored. There were arrangements in place for medicines which required additional security. An audit system was in place to carry out daily, weekly and monthly checks of MAR charts, medicines stock and ordering. Suitable MAR charts were kept. There were no gaps on the MAR and they were clear and legible. Medicines were given to people at the correct times.

People did not benefit from a clean environment. The premises were not free from offensive odours. Odours of urine were noted in five bedrooms and a further two bedrooms smelt damp and musty. Some carpets were stained and dirty. One person's carpet was uneven and posed a trip hazard. We spoke to the registered manager about their cleaning arrangements. They told us they contracted a self-employed cleaner for two hours a day, three days a week and care staff cleaned during the other times. They admitted that this was inadequate as the cleaner came at the start of the day whilst people were being helped to wash and dress which meant the cleaner could not access their bedrooms.

The failure to ensure the premises is clean and well maintained is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we saw staff using appropriate protective clothing to reduce the risk of cross infection, such as aprons and gloves, when assisting people with personal care or with eating.

People were not protected from the risk of being cared for by unsuitable staff because the home's recruitment procedure was not robust. We looked at the files for three staff. In two files we saw an incomplete employment history which had not been explored. This meant the provider was not meeting the Schedule 3 requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 to ensure that staff employed, were safe to work at the home. Two records did not contain satisfactory evidence of conduct in previous employment, such as references. References on file were from family or friends. The registered manager had not done everything possible to assure themselves that people were protected from being cared for by unsuitable staff and although we did not find people had come to any harm as a result, this put people at risk of harm.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw police checks had taken place and were recorded in staff files.

People told us staff were too busy and had too much to do to spend time with them. One person said, "Staff

have got their work to do and they don't have time to sit and chat." One staff member told us, "The residents sit where they are every day with nothing to do."

At the time of this inspection, there were 16 people living at the home. We were told by the registered manager four people required the assistance of two care staff to meet their personal hygiene needs. Of the remaining 12 people, ten people required the assistance of one carer for personal hygiene and assistance with mobilising. In the mornings, there were three care staff on duty. One member of staff was responsible for administering the medicines, which left two staff to help people with their care needs. In the afternoon staffing was reduced to two care staff. The registered manager told us as well as the administration assistant, they were there to support staff most days. Rotas showed people were supported at night by two care staff, one sleeping and one awake. Since our inspection this has increased to two waking night staff.

In addition to supporting people with their physical care needs, staff were expected to prepare and cook all of the food, serve the meals, do the laundry and attend to some cleaning around the home. This meant staff did not have time to support people in a person centred way.

Our observations showed there were a number of times when communal areas were left unsupervised. We observed long periods of time where people sat in the lounge with little to occupy their time, looking disengaged and under stimulated. Interaction between staff and people was often only initiated when they needed support with a physical care task, for example, when they needed to visit the toilet or needed support with their meal. Staff were seen to be busy around the home attending to tasks such as laundry, rather than spending time with people.

We spoke to the registered manager about our observations and asked them how they worked out their staffing. They told us they did not have a system in place to determine the number of staff they needed to meet the physical and social needs of people living at the home. They agreed with our observations that people spent long periods of time without social interaction and said they had spoken to staff about this in the past.

Failure to provide sufficient numbers of staff, and deploy staff in a way that ensures people's needs are met, is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People told us they felt safe living at Rosemount and with the staff supporting them. People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and understand what action to take. Staff told us if they had any concerns they would report them to management and believed they would be followed up appropriately.

Records of any accidents and incidents were recorded and analysed to check if there were any themes.

Equipment including hoists and stair lifts had been regularly serviced. There were gas and electrical safety certificates. There was evidence of legionella testing and of regular testing of hot water temperatures throughout the home.

Requires Improvement

Is the service effective?

Our findings

Care was not always effective because staff did not always have the skills, knowledge or training to meet all of the people's needs. Referrals to healthcare professionals were not always made and staff did not always act on instruction and guidance from health professionals. The environment was not suitably adapted for people with dementia.

People did not always receive support from staff with the knowledge and skills they needed to carry out all aspects of their roles. One person was admitted to the home with specific health needs. The registered manager had not made sure that staff received training necessary to meet the person's needs and keep them safe. For example, they were living with diabetes and this was managed with injections of insulin. Staff had not received training in the care and support of people living with diabetes. We spoke to staff about diabetes and what they needed to be aware of to keep people safe, such as, signs and symptoms to look out for if a person became unwell. Staff did not demonstrate knowledge in this area. The person also had a urinary catheter. Some staff were able to tell us about catheter care as they had had previous experience. However, we found other staffs' knowledge about possible complications, was minimal. Staff had not received any training about catheter care prior to the person's admission.

We asked to see the home's policy relating to diabetes care. The registered manager did not have this available and had to print it off from an on-line quality assurance and care management system that provided the home with policies. The home's 'Diabetes Policy and Procedure' stated, "All staff who support people living with diabetes will maintain their knowledge, skills and competence. Training will be sourced and included in Rosemount Residential Home's training plan." The registered manager had not followed their policy and this put people at risk because staff did not have the skills and information needed to deliver care and support to people safely and appropriately.

Two people living at the home were being supported to eat safely as they had swallowing difficulties. We spoke to staff about how they supported people to eat safely. Staff did not always demonstrate full understanding of the risks and what action they may need to take. Staff told us they had not received training in supporting people with swallowing difficulties.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A system was in place to monitor staff training to show what training each staff member had completed. Staff told us their training involved completing workbooks. Most of the staff told us they were happy with the training on offer but would prefer more face to face training. One member of staff said, "Face to face training would be better, you can ask questions and discuss things. You can't do that with our training." Staff received training which the registered manager considered essential to their roles such as, manual handling, fire safety awareness and infection control.

Staff were supported by regular supervision and appraisal. Staff said they could approach the management team at any time for support and guidance.

Records showed people were seen by healthcare professionals when the staff observed changes in their health and well-being, as well as for routine checks such as from an optician and chiropodist. A visiting healthcare professional told us they had no concerns about the home.

However, we also found referrals to healthcare professionals were not always made which meant people were not always provided with appropriate support when necessary. For example, staff did not alert the community nurses about one person who had developed a pressure ulcer whilst in hospital, despite the hospital requesting staff to take the appropriate action when the person returned to the home. There was no skin care plan or body map completed and the only reference to this pressure ulcer was an entry in the daily records two days after the person returned to the home. Staff also failed to alert the community nurses when a person was admitted that required nurses to administer their insulin.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The environment was not suitably adapted to meet the needs of individual's living at the home who were living with dementia. National good practice in dementia care suggests that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors should be in a contrasting colour as should toilet seats and handrails and there should be easy to read signage. Only some people had a photograph of themselves on their bedroom door and there were minimal pictorial signs on bathroom and toilet doors. Seating in the lounge room was institutional with chairs placed around the walls. This discouraged conversation and engagement.

We recommend that action is taken to review the accommodation with regard to best practice guidance about creating dementia friendly environments.

People told us they enjoyed the meals provided by the home. One person said, "The food is fairly good" and another person told us their lunchtime meal was "lovely." Although people told us they were happy with the food, we saw the food on offer was reheated from frozen, generally from the basic supermarket range and there was no fresh fruit or vegetables available. The home offered a choice of two main courses each day and staff told us if people wanted something else they could. However, we didn't see any evidence of alternatives being offered or provided during our inspection. On the first day of the inspection a white board in the dining area displayed the menu for that day. This menu was not changed on the other two days of inspection. People told us they did not know what was for lunch. There were no drinks or snacks available for people to help themselves to if they wished.

We recommend the home review the food available to people, the options on offer and the nutritional value of the foods offered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on

authorisations to deprive a person of their liberty were being met. Care files contained capacity assessments. There was evidence the home had thought about people's needs and relatives had been involved in making best interests decisions. Records confirmed applications had been submitted appropriately to the local authority for their authorisation.

Staff had received training in the Mental Capacity Act and were aware of the need to gain people's consent when providing them with care and support. We observed staff usually asked people for their consent before assisting them with daily tasks. However, we did see some staff putting protective clothing on people before they ate without asking for their consent or informing them of what they were doing.

Inadequate

Is the service caring?

Our findings

People had mixed opinions about Rosemount and the staff. One person said, "All the staff here are very nice." Another said, "Sometimes I think it's wonderful but other times I think I don't want to be here." A relative told us, "We've been really pleased with everything."

We found the culture and leadership in the home did not promote caring. The relationships between staff and people receiving care and support did not always demonstrate that people were treated with dignity and respect. There was a task orientated approach to the way staff ran their shifts. We observed on occasions, staff would walk into a room and not acknowledge the people there because they were focused on something else. We did not see staff spending any length of time sitting talking with people.

People's dignity was not always promoted. At lunchtime we saw staff put a protective tabard on everyone sat at the dining tables. No one was asked if they wanted to use the tabard or if they would have preferred another way of protecting their clothes such as a napkin.

When we spoke with staff about people needs, some staff spoke in a disrespectful manner about the people they supported. For example, one staff member referred to people as "feeders" meaning people that needed help or assistance from staff to eat their meals.

People did not always live in a pleasant smelling, clean environment. Throughout the inspection, we noticed some people's bedrooms had a strong smell of urine and others smelt damp and musty. We brought this to the attention of the registered manager on the first day of the inspection, but no action was taken.

We saw some people's rooms were personalised with pictures, ornaments, photographs and other treasured possessions. In contrast we saw other rooms were sparsely decorated, dark and did not feel homely or welcoming. One bedroom that had been used for double occupancy was now being used for one person. However, the second bed had not been removed and this restricted the area the person had for their use. We saw the room was dark, there were no decorative items in the room, the furniture and décor were in poor condition and the other unoccupied bed was used to store boxes, a pressure relieving mattress and a hoist. We asked the registered manager why this room was so empty and bleak and they told us the person did not have any furniture of their own. However, we saw that no attempt had been made to make this room more comfortable, welcoming or homely and did not demonstrate the person was valued and cared for. We spoke to the person about their room but they were unable to share their views with us and there was nothing in their care plan about their room preferences.

We also observed continence products left in people's rooms which showed a lack of respect for people's dignity.

The failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect).

We did see instances where staff respected people's dignity. We observed staff knocked on people's bedroom doors and waited for an answer before entering. Staff ensured personal care was carried out in areas where people's privacy could be maintained.

One member of staff told us, "I like working here" whilst another said, "I love working here. The residents are lovely."

We saw staff supporting people in a caring way. We saw people were relaxed and happy in staffs' presence. Staff spoke about people with affection. When staff interacted with people they were patient and encouraged them to retain their independence when moving around the home. For example, we saw a member of staff spent time with a person encouraging them to walk to the toilet. People were encourage to make choices. for instance, where they wanted to sit and spend their time.

Visitors were welcome in the home and there were no restrictions as to when they could call. Relatives told us they were made to feel welcome when they visited.

Inadequate

Is the service responsive?

Our findings

The home was not responsive because people did not receive consistent and personalised care, treatment, and support; staff did not always have the information they needed to support people appropriately; people did not have access to person centred activities and were not encouraged to maintain their hobbies and interests.

Before the inspection CQC was made aware that one person had been admitted to the home without the necessary arrangements in place to ensure staff could meet their needs in a person centred way. The registered manager told us they carried out an initial assessment of each person's needs before they moved into the home. The registered manager confirmed they had visited this person in hospital a week before they were to be admitted to ensure they could provide the level of support the person needed. This initial assessment was to form the basis of a care plan. However, despite identifying their health care needs the registered manager had failed to ensure they had everything in place and staff had the necessary skills and knowledge to meet the person's needs. The registered manager had failed to ensure a care plan was completed that met the person's emotional, social and health care needs in a person centred way. They had failed to accurately assess, plan, manage and mitigate known risks. These included, the management of their diabetes and catheter care. We looked at this person's care plan and found staff had not been provided with sufficient information on how to recognise signs and symptoms that would indicate this person was becoming unwell and what action staff should take.

Care plans contained inconsistent level of detail and information about people's preferences, likes and dislikes. Some care plans provided guidance for staff to follow when supporting people with their individual needs, for example, '[name] likes to drink tea from a mug, milk no sugar, and has her own mug, white with red poppies'. However, not all care plans contained this amount of detail. Some sections of care plans had not been completed, such as; personal profiles, life histories, social and leisure preferences and medical history. This meant staff may not know important information to ensure people's choices were respected, in particular when the person had difficulties in expressing their wishes verbally. Personal life histories capture the life story and memories of each person and help staff deliver care responsive to their needs. They enable the person to talk about their past and give staff an improved understanding of the person they are caring for.

One person admitted to the home on 6 April 2018, did not have a care plan. Their records did not contain information about their medical, social, personal or life history. No assessments had been completed prior to the inspection such as; mobility, nutrition, skin condition or physical health. No care plans had been written. This meant that staff did not have information available to ensure they met the person's choice, wishes, preferences or needs. Although they did not have a care plan in place, the person had not come to any harm.

People did not always have their care plan updated when their needs changed. For example, one person's moving and handling care plan and falls risk assessment said they were able to mobilise with their frame with the assistance of two staff members. During the inspection we were told by staff the person was

transferred with the use of a hoist. We saw from daily records from January 2018 the person was being transferred by using a manual sit-to-stand transfer aid which then progressed to an electronic stand aid hoist 23 January 2018. Their care plan or risk assessment had not been updated to reflect when their needs changed. This meant there was a risk people's needs and wishes may not be respected and followed by staff.

Plans for care did not put people first or demonstrate people were given choices around their care. We did not see evidence in people's care plans that people and relatives, where appropriate, were involved in the planning of their care. Care plans contained inconsistent level of detail and information about people's preferences, likes and dislikes; for example, preferred routines and food and drinks. This meant staff may not know important information to ensure people's choices were respected. We found an inconsistent level of detail about people's families, friends and life histories. This meant that staff may not have information about people's lives that may help them to engage people in conversation or encourage links to be maintained.

Daily observation records were completed to record the support provided to each person. In most cases, these contained little or no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues, such as, social isolation. This showed us that although there was up to date information about the support provided, the information was not person centred.

Care plans did not contain detailed information about people's hobbies, interests, and activities they enjoyed.

People did not benefit from activities or engagement that had been designed to address issues such as preventing isolation, helping to maintain the person's identity, and helping the person feel valued, helpful and involved. There was no evidence people had been supported to follow their individual interests. We saw people appeared withdrawn and disengaged with the environment. People were sat in the lounge or alone in their rooms for long periods of time just looking around or falling asleep.

During the three days of the inspection, we only witnessed two people engaged by staff in meaningful activity. We saw objects, pictures, games, books and magazines which could be used by staff to make meaningful contact with people. However, they were not using these to engage with people. Staff used the television as the only form of entertainment. The majority of people were not watching the television and staff did not ask people if they wanted the television on or what they wanted to watch. During lunch, staff put music on but again people were not consulted about this or what was played. We observed the same CD was played during all three lunchtimes. There was no list of activities on offer or displayed anywhere around the home.

The registered manager told us they employed an activities co-ordinator for two hours a day, four days a week. However, we saw from rotas from the 30 April 2018 to 3 June 2018 this was not always the case. We spoke to the activities co-ordinator on the last day of the inspection when they returned to work. They said they were very limited in what they could offer people. Activities they did offer included board games, arts and crafts, a pamper day and bingo. They told us they found it very hard to persuade people to take part in activities and tended to engage with people on a one-to-one basis, but this meant they were only able to involve a small fraction of people living in the home, in meaningful activity. They told us, "People sit where they are every day with no other activities." They went on to tell us the home had not had outside entertainers visit for over a year and no-one went out-side unless they went with their family. We saw that people could go out to a patio area but this was a concrete area with only old shabby chairs for people to sit

on and was not a pleasant place to sit. People also had access to a roof garden which was also in the same state of dis-repair.

Some people were happy with the activities on offer and some people told us they preferred to stay in their rooms. We asked people how they spent their time and if there were many activities for them to choose from. Comments included, "No not really, nothing going on. Bingo on a Friday if you like it. I don't", "Not much happening during the day" and "There's nothing going on, nothing to do. Plenty to read." Another person said, "I like to stay in my room, I'm happy."

People were not always supported to have a dignified death. Some people had treatment escalation plans which outlined plans for if a person's health deteriorated. It included their wishes and needs should this happen. However, other people's care plans did not contain information about their needs and wishes for the end of their life. Care plans focussed on people's death rather than their aspirations or final wishes. By not having this information staff would not know if there was anything important to the person to support them prior to their death.

The lack of an accurate care planning information and failure to provide care and treatment in a person centred way meant people were at risk of inconsistent care or not receiving the care and support they needed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see any evidence of information being available in alternative formats, such as large print or picture format. The registered manager was not aware of the Accessible Information Standard. The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans contained an assessment relating to the Accessible Information Standard, which covered people's eyesight and hearing. However, this information was brief and did not contain detail.

Records showed that staff had not received equality and diversity training to ensure they understood how to protect people's rights and lifestyle choices. This meant there was a risk people may be discriminated against due to their disability, race, culture or sexuality. Care plans recorded important information about people's relationships with others and those important to them. People's religious and spiritual identity was documented although this information did not show how any needs were being met.

The registered manager had a written complaints procedure, which detailed how complaints would be managed and explained how people could escalate their complaints if they were not satisfied with the provider's response. Information about how to complain was provided to people and their relatives when they moved into the home and was displayed in the entrance to the home. Where complaints had been received, these had been investigated. There was a box in the reception area for visitors to post any concerns.

Inadequate

Is the service well-led?

Our findings

Rosemount has not been able to meet the CQC regulations over a sustained period. Over ten inspections, carried out between 2012 and 2018, the home has only met all of the regulations inspected on four occasions. In March 2017, the home was rated "requires improvement" and the local authority quality monitoring team worked with the provider and staff to support them to bring about improvements. In November 2017 the home was rated as "good" after improvements were made. Evidence gathered during this inspection shows the service has not been able to maintain these improvements as seven breaches of regulations were found. During this inspection we have found people were not receiving a safe, effective, caring, responsive, or well-led service.

We have shared our concerns with commissioners and the safeguarding team.

On 4 June 2018, a multiagency safeguarding meeting was held. As part of that a plan was put in place, with the agreement of the provider, health and social care professionals, to protect people's safety and wellbeing. This included health professionals visiting the home every day in a support and protection role. People's care needs are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are again working with the provider and staff to support them to bring about improvements.

There was a manager registered with the Care Quality Commission (CQC). 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. The registered manager who was also the registered provider was supported in their role by a deputy manager and an administrative assistant who was to be responsible for quality assurance audits and ensuring staff received appropriate training and supervision.

Although people and relatives told us the registered manager was approachable and accessible, their lack of effective leadership and governance impacted on the effectiveness and safety of the care and support people received. The registered manager had not learnt from the previous breaches of regulations to ensure this did not happen again. They did not demonstrate a pro-active approach to ensure previous improvements were sustained. Care was task orientated which meant people did not benefit from a personalised and empowering approach. There was a lack of oversight of the service by the registered manager which allowed poor practice and inconsistent care to be delivered.

People were at risk of poor care because the registered manager was unfamiliar with their own policies and procedures. During the inspection we asked to see a number of policies relating to the running of the home. The registered manager told us they subscribed to an online quality assurance and care management system that provided a range of products for use by care homes such as, policies and procedures. However, the registered manager had not downloaded and printed off the policies and procedures necessary to meet the needs of people living at Rosemount. These policies were not readily available to staff and the registered

manager had not read them, therefore they could not be sure staff adhered to them. For example, we saw examples where staffs' practice did not adhere to the home's 'Medication Policy and Procedure', 'Catheter Care Policy', 'Diabetes Policy' or 'Choking Policy'.

Although the registered manager had a quality assurance system in place, this was not effective as it had not identified the risks and issues we found during our inspection.

People were not protected from the risk of harm as they were living in an environment that was not safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated. The registered manger was reactive rather than proactive in their approach to monitoring the quality of care being provided. For example, they addressed some issues such as risks in the environment, but only when we pointed them out.

The care plan reviews and audits had not identified that some health care risks to people had not been assessed or that some risks did not have associated care plans with guidance for staff to follow. The audits had not identified that care plans were not always in place, up-to-date, person centred and did not always have the level of detail staff required to carry out their roles safely. We found that where care plans had been reviewed changes to people's needs were not always recorded and acted upon.

Quality assurance systems had not identified that staff did not have the skills and knowledge they needed to meet all people's needs. The registered manager had not identified that there were times when people were not always treated with dignity and respect.

Arrangements for recruiting staff did not adequately protect people. Although, the provider had a recruitment procedure and policy in place, the quality assurance systems had not identified where checks had not been completed. This meant they did not have a robust system in place to ensure all staff recruited were safe to work with people who are vulnerable due to their circumstances.

The registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. Not all risks had been assessed and mitigated.

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

The registered manager and staff were open and cooperative during the inspection. Staff told us they enjoyed working in the home and the staff team worked well together. Staff told us they felt supported by registered manager. Staff said they could approach the manager with any concerns and felt they would deal with concerns appropriately. We saw that one-to-one supervisions and yearly appraisals for staff were taking place. Staff knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices.

The home obtained feedback from people and relatives to identify areas that needed improvement and to assess the impact of the service on the people using it. The registered manager sent out questionnaires. Previous questionnaires had not highlighted any issues. People also had the opportunity to attend residents meetings, which we were told took place regularly. We saw from the minutes of the resident's meeting in March 2018 people and staff discussed food choices and preferences, any concerns and feedback about activities.

People's personal confidential information was held securely and only staff had access to records and personal information relating to people living at the home.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware they had to inform CQC of significant events in a timely way and notifications had been received appropriately since our last inspection.