Rossmore Nursing Home Limited

Rossmore Nursing Home

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

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014. This was also part of a pilot for the new inspection process being introduced by CQC. The inspection was unannounced.

Rossmore Nursing Home provides accommodation and nursing care for up to 56 people accommodated over two floors in a series of large terraced houses. The home also provides a stroke rehabilitation service for up to 12 people. The stroke rehabilitation unit operates as a separate facility on behalf of the Hull Clinical Commissioning Group (CCG).

The home had a registered manager who had been registered since November 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Before this visit we had received information of concern about staffing levels at the home, especially at night, staff training and people's care, treatment and support needs not being met. During our visit we found evidence to support this information.

We found systems and processes to keep people who lived at the home safe were unsafe in that people were not protected from the risks associated with the unsafe use and management of medicines. Medicines at the home were not handled safely, securely and appropriately. The problems we found breached Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People were not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean and hygienic environment. The problems we found breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. This included care records and records relevant to the management of the service. Documents held by the home were frequently found not to be up to date or were absent. These included policies and procedures, management records, meeting minutes, accident and incident reports, supervision and appraisal records, audit records and complaints. The problems we found breached Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

There were not enough qualified, skilled and experienced staff to meet people's needs safely and in a timely manner. The problems we found breached Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Training for new and existing staff required improvement to ensure they had the skills and knowledge required to carry out their roles. Staff did not receive appropriate professional development, supervision and appraisal. The problems we found breached Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Assessment and monitoring of the quality of the service provided was inadequate and the issues we found during the inspection had not been identified by the provider. There was no evidence of follow up of audits and satisfaction surveys or any systems or processes in place to demonstrate to us the home had an effective quality management system. The complaints system was not effective; comments and complaints people made were not responded to appropriately. The problems we found breached Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The design, layout and lack of maintenance of the home's premises and surrounding grounds did not promote people's wellbeing.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards and had recruitment processes in place which protected people from unsuitable or unsafe staff.

The home was meeting people's nutritional needs; people were supported to ensure they had enough to eat and drink. People told us the food at the home was good and they got a choice.

People we spoke with and their relatives told us they were happy with the care provided at the home and people's care and treatment needs were being met. From our observations, and from speaking with staff, people who lived at the home and relatives, we found staff knew people well and were aware of people's preferences and care and support needs.

Staff involved people in choices about their daily living and treated them with compassion, kindness, and respect. People were supported by staff to maintain their

Summary of findings

privacy, dignity and independence. We saw most people looked clean and well-cared-for. People had access to activities and relatives and friends were able to visit the home at any time.

People were supported to access external healthcare professionals as and when required. The local GP visited the home once a day and physiotherapists and occupational therapists came to the home every day to work in the stroke rehabilitation unit.

Summary of findings

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. Medicines were not managed safely and appropriately. Nursing staff told us the medicines round took several hours to complete, especially in the evening. This meant people were at risk of not receiving their correct medication or it may not be given on time.

Areas of the home smelt of urine and the premises did not provide a clean and hygienic environment for people to live in. Infection control was not well-managed and training in infection control for 35 of the 50 care staff was out of date. This meant vulnerable, and often frail elderly people were not being protected from the risk of acquiring preventable infections.

Some people's care and nursing records were inaccurate and not up to date. This meant people who lived at the home were at risk of receiving inappropriate care and treatment. Records relating to the management of the home also required improvement to ensure they contained up to date information and were fit for purpose.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards. These safeguards provide a legal framework to ensure that people are only deprived of their liberty when there is no other way to care for them or safely provide treatment. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and knew how to ensure the rights of people with limited mental capacity to make decisions were respected.

Is the service effective?

Requires Improvement 

The service was not effective. People, relatives and staff told us they felt people who lived at the home received good care. However, records showed none of the 50 care staff at the home were up of date with all of the training they required to carry out their work. This included safeguarding, infection control, health and safety and fire safety. Records showed staff were not receiving regular supervision and appraisal to monitor their performance and development needs and ensure they had the skills and competencies to meet people's needs.

The premises and surround grounds were inadequately maintained which created risks for people who lived at the home, staff and visitors.

People's nutritional and hydration needs were generally being met. We saw the menus offered variety and choice and people with specific nutritional needs, such as soft or pureed diets, were catered for.

Summary of findings

Individual risks to people had been identified and assessed as part of the care planning process. There was evidence of referrals to external healthcare professionals where people needed extra help and support to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring. Although we saw individual staff treated people with kindness and respect, there were examples where staff did not provide care consistently or in a way that promoted people's dignity. This was because the provider did not ensure staff had the resources, time and training to be caring.

People were involved in making daily decisions about their life at the home, such as where to sit and what they would like to eat. Staff took account of their individual choices and preferences. Whilst we saw some evidence to show people were involved in planning their care at the home, none of the people we spoke with said they were involved or included in planning their care.

People told us they were happy with the care at the home and their treatment and support needs were being met. Staff obviously knew people well and interactions between staff and people who lived at the home were friendly and helpful.

Is the service responsive?

Requires Improvement

The service was not responsive. Staffing levels were insufficient to meet people's needs; this was partly due to vacant posts and a lack of robust contingency plans to cover for staff absences. The home did not use a dependency tool to determine what the safe and appropriate staffing levels should be. This meant the management at the home did not respond in a timely way to ensure sufficient staff were on duty. People we spoke with, relatives and staff all told us they felt the home was short of staff. This meant people who lived at the home may experience inappropriate care, or have to wait for long periods before staff could help and support them.

Complaints were not fully investigated and responded to appropriately and there was no system in place for capturing complaints or concerns raised verbally. This meant there was no evidence to show us whether concerns or issues people raised were dealt with appropriately.

A range of activities were available at the home and we saw the activities co-ordinator encouraging people to join in with them. There was a weekly rota of activities; these were distributed throughout the home and in people's bedrooms.

Is the service well-led?

Inadequate

The service was not well-led. The home's quality assurance processes were ineffective and inadequate, particularly in relation to medication, infection

Summary of findings

control and record-keeping. Audits were lacking in detail, and sporadic; there was no audit schedule and actions were not identified or followed up. We found this placed people at risk of unsafe or inappropriate care. Feedback from people, via satisfaction surveys, had not been followed up.

Accidents and incidents were documented but trends were not monitored and analysed. This meant people who lived at the home may be put at risk of harm.

The home did not promote a fair and open culture where staff felt they were well-led and supported. Staff told us management at the home were often resistant to suggestions about improvements.

Rossmore Nursing Home

Detailed findings

Background to this inspection

The inspection team was made up of two inspectors, a specialist advisor (who was a general nurse with experience of stroke rehabilitation), and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this visit we had received information of concern about staffing levels at the home, especially at night. The lead inspector and specialist advisor arrived at the home at 7am in order to speak with the night staff before they went off duty. The second inspector and expert by experience arrived at the home at 9am. The inspection team stayed at the home all day, and left after feedback was completed, at 5pm. One of the inspectors on the team visited the home for a second day, four days after the first visit; this visit was also unannounced.

Before the inspection all the information we held about the home was gathered and reviewed. This included notifications the home had submitted to CQC, the whistle blowing concerns which had recently been submitted and the provider information return (PIR). The PIR is a document completed by the provider about the performance of the service. The local authority safeguarding and contracts teams were contacted before the inspection, to ask them for their views on the service and whether they had investigated any concerns.

The inspection team used a number of different methods to help them understand the experiences of the people who lived at the home. They used the Short Observational Framework for Inspection (SOFI) in the lounge in the nursing unit during the morning. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. They also spoke with the provider, who was the managing director, the registered manager, three registered nurses (one of whom had worked the previous night), 13 care workers (four of whom had worked the previous night), the home's regular GP, a visiting healthcare professional, six people who lived at the home and two relatives.

The inspectors also looked around the premises, including people's bedrooms, bathrooms, toilets, communal areas, sluice rooms, the kitchen and outside areas. They observed staff interactions with people who lived at the home and looked at records. Eight people's care records were used to pathway track people's care. Management records were also looked at, these included; five staff personal files, policies, procedures, audits, accident and incident reports, specialist referrals, complaints, training records, staff rotas and monitoring charts in people's bedrooms.

The registered manager told us there were 49 people living at the home on the first day of the visit. Ten people were living in the stroke rehabilitation unit, four were on respite care, 17 required residential care, 15 required nursing care and there were three young disabled people.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

During our discussions nursing staff told us it took a long time to do the medication round. In particular at night there was one nurse on duty who had to do the evening medicines for up to 56 people. They told us this could take them until midnight to complete, and that was if they didn't get distracted. Other nurses we spoke with confirmed that all of the medication rounds took three to four hours. This meant people who lived at the home may not get their medicine in a person-centred way or on time.

We found examples in care records where people had missed their prescribed medication, either because it had run out or a new prescription had not been delivered to the home. One person, whose care plan stated they were very anxious, had been prescribed an antidepressant medicine which they did not receive until four days later. This could have impacted on their health and welfare during this period. This showed us people who lived at the home may be put at risk, as they were not always having their medicines as and when they needed them.

We found medicines were not appropriately or securely stored on the stroke rehabilitation unit. The audit of the controlled drugs, which had been due at the weekend prior to our visit, had not been carried out. We also found expired medicines and medicines which were no longer required and should have been returned or destroyed. Unopened food supplements, which should have been stored in a cool place, were observed on the floor in the kitchen of the rehabilitation unit. This meant they were not being stored at the correct temperature. The temperature of the medicines fridge had been checked; however the record book was falling apart leading to records being lost. This meant medicines were not being handled safely, securely and appropriately.

We found the GP, pharmacy and nursing staff in the stroke unit were already aware of the issues relating to medicines management which we identified. They told us they were reviewing the processes at the home. We were told the pharmacy which supplied medicines to the home had carried out a recent audit; however the results of this were not available. The registered manager told us they were currently rewriting the policies and procedures for medicines management at the home. This showed us the home was taking action to improve how medicines were managed.

On the second day of our visit we found two new medicines trolleys had been purchased and medicines at the home were stored securely. The home's pharmacy was changing people's medicines onto a monitored dosing system (MDS) on 28 July 2014 and the home's pharmacy was due to carry out another audit in the stroke rehabilitation unit on 29 July. This showed us the home had taken some actions to resolve of the issues we identified on the first day of the inspection.

The problems we found with medicines management breached Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

On the first day of the inspection we looked around the premises and found they were not clean and there was a malodour throughout. We found the equipment in both sluice rooms had leaks which the provider and registered manager were not aware of. This meant soiled commode pots were unable to be cleaned and contributed to the unpleasant odours in the areas adjacent to the sluice rooms. We saw clinical waste was not stored securely and flies were apparent around the yellow bags in the unlocked and open clinical waste bins.

There was no hot water at the majority of the wash hand basins in all of the areas of the home. When we raised this with the owner they told us they were aware this was an issue and had replaced all but one of the boilers at the home over the previous three years. We saw evidence of many attempts by the registered provider to rectify this issue. They assured us they would call in the gas company again.

We found multiple examples of inadequate cleanliness in communal bathrooms and toilets. These included brown and yellow coloured staining and build-up of waste products. We saw that this included door handles, light pulls and toilet brushes, many of which were inadequately clean.

When we spoke with the cleaners they understood that their role was to keep all areas as clean as possible. They told us:

"We never stop and it doesn't always look any better when it's done."

Inadequate

Is the service safe?

"There are two teams of cleaners and two handymen; you can't keep on top of it."

On the second day of our visit, we found the provider had taken some actions to address the infection control issues we had identified. For example, the bathrooms and toilets had been 'deep cleaned,' boiler repairs had been carried out and hot water was now available on the first floor.

People were not protected from the risk of infection because they were not cared for in a clean, hygienic environment and staff training in infection prevention and control was not up to date. We reported what we had found on our visit to the contracts department at the local authority.

The problems we found with infection prevention and control breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We interviewed the GP who visited the home for an hour a day. They raised some concerns regarding time delays in obtaining medical information when people were admitted to the stroke rehabilitation unit. The provider told us they were aware of this issue and had made efforts to rectify this.

We looked at the care plans of two people whose nutritional assessments had identified they were at risk of malnutrition. They had both lost weight recently and been referred to a dietician. Their care plans documented that food and fluid charts were required to monitor their food and fluid intake. However, when we looked at these people's food and fluid charts we saw there were gaps where meals and drinks had not been recorded. We showed one person's charts to a care worker, who confirmed this person had not been offered fluids every hour which went against the instruction within their care plan. This meant that these people may not be receiving adequate levels of nutrition and hydration.

The registered manager told us they assessed people before they moved into the nursing home. We saw assessments within the care plans. Records showed people's care planning documents had been regularly reviewed, on a monthly basis, by nursing staff. However, most of the entries stated, "No changes." We found examples where people's care needs had changed and the associated care plan had not been updated. For example one person's moving and handling care plan review from August 2013 stated, "Will need a hoist soon." All of the monthly entries since that date recorded "No changes." We found this person currently needed a hoist for all transfers. This meant people who lived at the home may be put at risk of inappropriate care and treatment.

We found no records were kept of the moving and handling training and competency assessments undertaken by care staff during induction. Once this had been brought the registered manager's attention, the inspector saw this had been actioned by the second day of the inspection. We examined 36 staff training records and these indicated that 83% of these 36 staff had not had received moving and handling training or update during the previous 24 months.

We found the outcomes of the multi-disciplinary meetings and the actions required were not clearly documented in the care plans for patients in the stroke rehabilitation unit. This meant the meetings held at the home were not as effective as they should be.

The problems we found with records breached Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). These safeguards provide a legal framework to ensure that people are only deprived of their liberty when there is no other way to care for them or safely provide treatment and to ensure that people's human rights are protected. We saw one person who lived at the home had a DoLS authorisation in place. This had been put in place because this individual was considered to be at high risk should they leave the building unaccompanied. We saw documents which showed us the provider had made other applications to the local authority safeguarding team to deprive someone of their liberty. This showed us the provider was aware of their responsibilities to protect people using this legislation.

Staff we spoke with knew about safeguarding vulnerable adults and were clear about how to recognise and report any suspicions of abuse. Staff knew how to access appropriate outside agencies to raise concerns. This showed us staff were aware of the systems in place to protect people and raise concerns.

Inadequate

Is the service safe?

In some of the care plans we looked at we saw mental capacity assessments had been carried out and staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005. However, staff training records showed none of the staff at the home had received any training in the requirements of the Mental Capacity Act or DoLS. We have asked the provider to ensure staff receive appropriate training in this legislation.

We looked at the recruitment records for five staff members. We found recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. This showed us the provider had taken steps to protect people who lived at the home from staff who were known to be unsuitable to work in a care home.

Requires Improvement

Is the service effective?

Our findings

We asked the registered manager and the staff on duty about the staff training provision and what measures were in place to ensure staff received adequate support.

We found the home did not have a training policy or a training matrix to record the dates and training courses staff had undertaken. Training records showed that none of the 50 care staff working at the home were up to date with all of the required training appropriate to their work. This included topics such as infection control, health and safety and fire. This meant people who lived at the home could be put at risk of unsafe or inappropriate care and treatment.

We spoke with one new member of staff who told us they had received training in fire safety before they started work at the home, but not in the other subjects considered mandatory by the provider. They said, “My induction consisted of two weeks ‘shadowing’ a senior member of staff; I haven’t attended any other training.” This showed us the home did not always ensure new staff were provided with the skills and knowledge necessary to undertake their role effectively and safely.

We discussed training, including induction training, with the provider and registered manager. The provider showed us individual training records for 36 care staff. The provider and registered manager were unable to provide us with live details about staff training, such as who had done what in each topic or what percentage of staff were out of date. We found two senior staff were qualified to deliver moving and handling training. New staff were trained in moving and handling during their two weeks shadowing and their competency assessed before they carried out any moving and handling procedures. When we spoke with staff about their moving and handling training they confirmed this. This showed us they had been trained to carry out the moving and handling required in their role safely. However, we found the majority of care staff had not received refresher training in moving and handling after their initial induction training. When we asked the provider and registered manager about this they were unable to tell us how long the induction training staff received during induction was valid for. They confirmed staff did not currently receive refresher training in moving and handling. The provider and registered manager told us they would ensure these deficiencies were rectified.

We asked staff whether they felt they had appropriate skills and knowledge to meet the needs of the people who lived at the home and keep them safe. One care worker said, "I've had mandatory training, health and safety, lifting and handling and fire, nothing else." A second care worker said, "Mandatory training only, health and safety, infection control, lifting and handling and fire."

Care staff we spoke with all had training and development ambitions which had not been discussed in a formal meeting with their mentor or line manager. We found staff at the home had skills and expertise gained in previous roles or employment which could be more effectively utilised /or further developed

The registered manager told us ‘dementia care mapping’ training was booked for staff in September and that kitchen and domestic staff would be included in this. The registered manager told us that they, and none of the care workers, were trained in medication administration. They told us they, and five senior care workers, were half way through a medications administration training course which would be completed in August 2014. They said this was so that care staff could assist the nursing staff with medication administration at the home. This showed us the home had some plans in place to provide additional training for staff.

We asked to see the staff supervision and appraisal records. Supervision sessions are used amongst other methods to check staff progress and provide guidance. These showed us that 20 of the 70 care and non-care staff had received supervision in 2014 and a further nine staff supervisions were planned for August 2014. We found there were very few staff supervision records dated prior to 2014. When we asked the provider about this they told us that when the registered manager started in post there was a backlog of work to catch up with and they were working together to get things back on track. They said, “We are hoping to get all the training records onto the computer. X (person’s name) is uploading them at the moment.” We were shown an ‘appraisal folder’, which demonstrated that staff were receiving regular appraisals.

When we asked care workers about their supervision and appraisal comments from two included, "Yes, I get supervision every year," and "It's done annually by X (registered manager) or Y (senior care worker)." Other staff we spoke with confirmed they had attended supervision recently, but couldn’t remember when they had last had

Is the service effective?

one before that. This confirmed what we had seen in the home's supervision and appraisal records. This meant staff had not been receiving regular supervision and appraisal and had limited information about training and development opportunities. Staff were also not receiving appropriate professional development; nursing staff did not have personal development plans.

The problems we found with staff training, support and development breached Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

We found that the home was housed in several buildings. Around half of the bedrooms were shared facilities which were occupied by two people and the remainder were single rooms. When we asked the provider whether people were asked if they minded sharing a room before they came into the home they replied, "They have to share when they are in hospital." We saw that each of the occupied bedrooms had the television on, whether or not the people could see it, and the majority observed could not comfortably see the screen.

People's bedrooms were mostly dark, requiring refurbishment, and felt airless. They were cramped with little storage; resulting in a general air of untidiness. We visited three dark, single bedrooms along a narrow corridor opposite the kitchen which were occupied. We observed a high level of noise coming from the kitchen and judged this could have a considerable disruptive impact on these occupants. We saw one of these people's care plans stated they should be in a room without disturbances and that a visiting professional had written, "Avoid noisy environments". On the second day of our visit we were told this person would be moving bedrooms.

When we spoke with people about the food at the home most of them told us it was very good and they got a choice. The provider showed us a folder they were preparing containing photographs of the home's food choices, this was to help people with communication difficulties to choose their meals. One person said, "The food is good, there are choices and I can eat in my room." It was a hot day when we visited the home and we saw people were offered cold drinks on a regular basis, and ice creams in the afternoon. We found the staff recorded people's dietary requirements in their 'nutrition and hydration' care plans. We observed breakfast in the dining room and lounge on both days of the visit and lunch on the first day and found these were relaxed, enjoyable, sociable experiences for people. This showed us the majority of the people who lived at the home were provided with a suitable choice of nutritious food and drink and were protected from the risks of inadequate nutrition and dehydration.

We looked at eight people's care records during our visit. We found people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan and in a way intended to ensure their safety and welfare. Care records were individually tailored to meet people's needs; appropriate care plans and risk assessments had been completed for each person. We saw evidence to show care records were regularly reviewed.

The provider described "good outcomes" for people, especially in the stroke rehabilitation unit. They told us the average length of stay was six to eight weeks. They related an example to us of a person who was admitted to the stroke rehabilitation unit on a stretcher; they said, "At the end of their stay on the unit, they went home able to cook their own breakfast."

Care records showed us people had access to health care professionals when they needed them. These included dieticians, speech and language therapists, physiotherapists, occupational therapists and social workers. This showed us people who lived at the home received appropriate additional support when required for meeting their care and treatment needs.

We found a number of different services were involved in the care of the people on the stroke unit. We found the GP for the home was contracted in for one hour per day Monday to Friday and support on evenings, nights and weekends was covered by the GP out of hours service. The therapy team, of physiotherapists and occupational therapists, based in the stroke unit were employed by the local acute trust. One healthcare professional told us the home was not always effective in acting on requests made to them by these various agencies. We also found examples of recommendations from healthcare professionals not being followed up in the care records which we looked at. This meant people being cared for in the home were at risk of inappropriate care or treatment.

Requires Improvement

Is the service caring?

Our findings

Our use of the Short Observational Framework for Inspection for just over an hour found most of the interactions between staff and people who lived at the home were positive, with no negative interactions. Throughout the visit all four members of the inspection team observed good interactions between staff and the people living at the home. However, feedback from people who lived at the home and relatives was mixed. One person, commented, "I don't expect them to chat to me, there's one who never smiles. How hard can that be?" Another said "Oh, we never have a cross word, I certainly feel well looked after."

People who lived at the home and staff we spoke with confirmed people were treated with respect and their privacy and dignity was maintained. When asked whether staff respected people's privacy and dignity one person said, " Oh yes, they are very respectful and always give me privacy to wash my private parts," and another said, " That's never been a problem, they're very good like that." This showed us people's privacy and dignity was respected.

People we observed in the communal areas of the home looked clean and well-cared-for. This showed us staff had taken the time to support people with their personal appearance. Most of the people who lived at the home we spoke with confirmed that they felt well-cared-for.

We observed people who lived at the home were given options about simple day-to-day decisions relating to immediate personal or social care. For example, where they would like to sit, what they would like to eat and whether they wanted to go to the toilet. Whilst we saw some evidence to show people were involved in planning their care at the home, none of the people we spoke with said they were involved or included in planning their care. When we asked the provider about this they told us, "Residents are invited to their reviews. Anybody that wanted to discuss it, we would. We have an open door policy."

The specialist advisor sat in on the morning staff handover at the home and found that verbal handover supported the details recorded in people's care records examined later.

When we asked five people who lived at the home and two of their relatives about care planning or long term care discussions they all told us they had not been involved in reviews of their care or in making any decisions about their care. Most of the people we spoke with were not aware they had a care plan and had not been asked to contribute to it. For example, when asked about care plans, one person who lived at the home said, "I don't know what that is. I don't think my care has been discussed, staff are usually brusque." Another person said, "No, what's that? I think they know what I need, it's up to them." A relative said, "I'm not involved with that but I think they've asked me in to talk about things." This showed us the home did not have systems in place to help people to be actively involved in making decisions about their care, treatment and support.

We saw staff were very busy and did not always have time to listen to people, or people were reticent to ask them to help them. People told us, and we observed, that most people who lived at the home were very aware of how busy the staff were. When we spoke with five people in their bedrooms one said they, "Wouldn't keep troubling these busy people." Three others told us, "They're such a busy crowd who don't have time to talk," "They're always rushing round doing things," and "They do their best but you don't always get chance to talk much." This showed us staff were task-focused and did not have the time to sit and talk with people for any meaningful periods of time.

When we asked five people about staff having time to meet their needs most people told us staff did not have time to speak to them, or that there were long waits to get an answer to their call bell. One person said, "You always get a cold drink but I occasionally really want a warm one and it's a hard and diplomatic process to get a cup of coffee." Another person told us, "The food's very nice, you can get whatever you want. They're looking after me alright." When we asked staff about meeting people's needs one said, "I think people get good care, I know some people do get lonely though." This showed us staff did not always have sufficient time to meet people's needs in the way they would prefer, or at the time they would prefer. Staff were often unable to respond to people in a caring and meaningful way.

When we discussed our observations with the provider and registered manager during feedback at the end of the first day of the inspection, the provider said, "I wouldn't disagree that the staff are busy."

All interactions observed showed respect for the people who lived at the home. People were asked for permission before personal cares were carried out. Those taking meals

Requires Improvement

Is the service caring?

in the dining room were offered choices as to where they would like to sit and what they would like to eat. People who were mobile appeared to have free movement around the home.

We found there were interpreting services for a person who's first language was not English and the registered manager told us, “We take smokers because a lot of other people won’t.” This showed us people’s diverse preferences and needs were accommodated at the home.

We asked the provider and registered manager about the use of advocacy services at the home. They told us they had not needed to use these recently, but had used them in the past and knew how to access services locally if required.

Requires Improvement

Is the service responsive?

Our findings

People and staff we spoke with all confirmed staff at the home were always very busy. Most of the people we spoke with told us the home needed more staff on duty. Staff told us there was a high turnover of staff, mainly on nights, and that working with new staff made it more difficult. We were told about, observed, and heard lengthy response times to people who rang their call bells. Comments from people we spoke with about call bell response times included:-

"You wait quite a while when you've rung, especially in the evening or at night;"

"People don't always come, handover times are a problem;"

"It's very frustrating, it feels like you have to wait half an hour;"

"They will come except when they are having lunch when they can't come."

We also observed people in a number of bedrooms where their call bell was out of reach, this meant they would be unable to summon assistance if they needed it. When we spoke with the provider about what we had observed they said, “I would not disagree that call bells in bedrooms are often out of reach.”

The home was very busy and people who lived there were highly dependent on staff assistance. For example, we found 14 people required hoisting by two staff and assistance with getting to the toilet and personal care. Several people were cared for in their bedrooms and a number of people needed staff to assist them with eating and drinking. Night staff we spoke with told us some people who lived at the home “wandered” at night and one person was on one-to-one care; this meant one care worker on duty had to supervise this person at all times. One of the nurses told us two people who lived at the home had a percutaneous endoscopic gastrostomy (PEG). This is an medical procedure where a tube (PEG tube) is passed into the stomach to provide a means of feeding when oral intake is not adequate. These two people needed significant regular assistance from the nurses for their nutrition, hydration and medication. This showed us there were people at the home who were highly dependent on staff input for their care.

When we spoke with care staff they confirmed that they did not have enough time to complete all of their required tasks.

When we asked the provider how they worked out how many staff needed to be on duty they told us they did not use a dependency tool; this is a tool which takes into account how much staff input each person requires to meet their needs. They told us the registered manager would change the number of staff on duty if they felt people’s care and support needs were not being met. When we spoke with four care workers they confirmed this had happened recently. They told us, “There used to be three care workers on at night; it’s a lot better now they have increased it to four.” One of the nurses we spoke with told us, “It’s quite a push at night, it’s not so bad for nurses during the day – there are three on duty up until 2.30pm.”

We looked at staff rotas and discussed staffing with the provider. They told us they rarely used agency staff as regular staff would usually pick up any spare shifts. The provider told us they were aware of the need for more nurse input at night.

There were not enough qualified, skilled and experienced staff on duty to meet people’s needs. People who lived at the home were safe and their health needs were generally being met. We observed staff working “flat out” with very little time to give people any social interaction. This meant the provider was not meeting people’s mental, social, and emotional needs.

The problems we found with staffing breached Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

We asked people whether they had ever had to complain about anything. People told us they were very happy living at Rossmore Nursing Home and that the staff and managers sorted out any problems straight away. When we asked five people what they would do if they had a complaint most spoke about mentioning any problems to the staff. We saw the home’s complaints policy was on display by the front door.

Comments from staff we spoke with about dealing with complaints included, "There's a protocol in place," and " I would tackle it immediately; there's no formal process."

Requires Improvement

Is the service responsive?

Records showed accidents and incidents were being recorded and appropriate immediate actions taken. Accident and incident records showed us there had been a lot of unwitnessed falls at the home and appropriate referrals had been made to the falls team after people had fallen. This showed us incidents which resulted in harm to people were followed up in a timely manner.

During the day we saw the activities co-ordinator encouraging people to join in with activities in the main lounge (in the nursing unit) and several people were taken into the garden outside the dining room. We also observed two people doing jigsaws in the main lounge and several people being given the newspaper of their choice around breakfast time. We also saw two people going out, one in a taxi which they did every day. We saw the activities co-ordinator kept a file of people's activities in the nursing unit. We also saw records for people in the stroke rehabilitation unit which identified their goals and daily activities. The five people we spoke to in their bedrooms were not able to tell us any activities that took place, even though staff reported quite a list of things on offer. Several people told us, "I like to watch television." One person said, "I have the radio on all the time, it keeps me in touch."

Inadequate

Is the service well-led?

Our findings

We asked the registered manager how the home obtained feedback about the quality of the service people received. They showed us six recent satisfaction surveys which had been completed. There was no evidence to show actions had been identified or followed up. The provider told us about how they organised residents and relatives meetings. The provider said, "We put up signs and send invitations out but it's extremely difficult to get people to come." Five people and two relatives told us they had never been asked had been asked to give their opinion, about their care at the home, either verbally or through a survey. This meant there was a lack of evidence to show us that people who lived at the home were given opportunities to feed back their experiences about how the service was run.

We asked to look at audits carried out at the home and were shown care plan and medication audits. We saw these were 'tick box' forms with no details or evidence of any actions identified or followed up. There was no schedule of audits to be carried out and significant areas which impacted on people's care and wellbeing, such as the environment and infection control, were not audited at all. This meant significant issues were not being identified and followed up. For example, we found equipment in both sluice rooms had leaks which the provider and registered manager were not aware of.

When domestic staff showed us their work task lists we found there was no evidence of specific directions or any monitoring of the quality or standard of cleaning at the home. This meant issues with cleanliness at the home were not being identified by the management and acted on.

When we asked the provider about management oversight of audits at the home they said, "I rarely check on the medication audits." They also said there were no external audits of medicines management at the home and added, "I've asked for one, we're expecting it but it's not been done yet." This lack of an effective system to assess and monitor the quality of service provided created risks that shortfalls would not be identified and rectified in a timely manner, by either the provider or registered manager.

We asked the provider and registered manager whether the home analysed incidents which had resulted in, or had the potential to result in, harm to people who lived at the home and they confirmed analysis of incidents was not carried out. This meant accidents and incidents were not acted on to prevent recurrence and trends and patterns could not be identified. The lack of analysis of incidents meant people who lived at the home may be put at risk. We also found preventive measures, and/or changes to people's care and treatment, were not always being put in place following incidents.

Two of the nurses we spoke to explained that the stroke rehabilitation unit and the nursing home were managed as two separate units. Some staff, including the nursing staff at weekends and nights, worked on both units and needed to know what the current procedures were in each. Our specialist advisor identified that there was no system in place to ensure changes in practice were communicated effectively at the home. For example, a new 'Drug Administration Policy' had been put in the front of the stroke unit kardex on 18 July 2014 (the Friday prior to our visit). Nursing staff told us there had been no discussions as to the changes in practice required in this policy.

Other care staff we spoke with also told us changes to policies and practices were not well-communicated across the home. When we asked the nurse on the stroke unit about communication between the two units they said, "I'm not really aware of what happens on the nursing side." This meant staff were not always aware of what had changed or what was taking place across all of the areas of the home. The lack of good communication systems across the home meant there was a risk that procedures may not be carried out correctly.

When we questioned staff about their responsibilities and whether they felt well supported by the registered manager and provider we got a mixture of positive and negative responses. Two of the staff we spoke with told us their views were taken into consideration and they could make suggestions in staff meetings or supervision. However, other staff told us they did not feel the home promoted an open and fair culture where they could make suggestions. This showed us that not all staff felt empowered and supported to question practice and give their opinion.

The registered manager had been registered with the Care Quality Commission since November 2013 and had been the deputy manager at the home before that. They had a National Vocational Qualification (NVQ) level 5 in leadership and management.

Inadequate

Is the service well-led?

We found there was a lack of clarity about the working relationships and areas of responsibility between the registered manager and the clinical leads at the home. For example, we found the registered manager was rewriting the home's medication policy. The registered nurses we spoke with told us the home's management meetings were held in the mornings; this meant they were unable to attend these meetings as they were doing the medicines rounds. When we asked the registered manager about the involvement of the nursing staff in the management of the home they told us, "It's very difficult to get the nursing staff involved." This meant appropriate professional and expert advice, which was readily available from the registered nurses at the home, was not being utilised as effectively as it could be.

There was insufficient evidence to demonstrate to us whether comments and complaints people made were responded to appropriately. We looked at the home's complaints file and saw there had been two complaints received since our last inspection visit. There was no evidence to show us what actions had been taken and whether the person who made the complaint was satisfied with the outcome. For example, after the last complaint we saw actions had been written up but no outcomes were recorded. The evidence we were shown by the registered manager failed to demonstrate whether the complaints system at the home was effective.

We asked the provider whether verbal complaints, comments and concerns made by people who lived at the home, or their relatives, were logged and acted upon. The provider and registered manager told us they had an 'open door' policy and dealt with minor issues as soon as they were brought to their attention. However, they could not show us any evidence to confirm this was happening. The provider and registered manager both confirmed there was no recording system in place at the home to log verbal complaints.

The problems we found with assessing and monitoring the quality of service provision breached Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

Staff we spoke with told us staff meetings were held at the home. They said meetings were supposed to be every month but sometimes it was every two months. The night staff we spoke with told us they came in during the day to attend the meetings in their own time. Staff told us minutes were given to staff individually and displayed on the notice board and they could contribute to the agenda. There was also a multidisciplinary (MDT) meeting on the stroke unit every week and the GP told us the staff in the stroke unit worked well together as a team. This showed us the home had some systems in place to ensure staff and other healthcare professionals were kept updated.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: People were not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected people against the risks associated with the unsafe use and management of medicines because the provider did not have appropriate arrangements for storing, recording and administering medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The registered person had not ensured there were sufficient numbers of suitably qualified, skilled and experienced staff to support people in meeting their health and welfare needs. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	How the regulation was not being met: Staff did not receive appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a)
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20 (1) (a)

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	How the regulation was not being met: The provider did not have an effective system in place to regularly assess and monitor the quality of the services provided. Regulation 10 (a) People were not protected against the risks of inappropriate or unsafe care by effective systems to assess and monitor their health, safety and welfare. Regulation 10 (b) The registered person did not analyse incidents that had resulted in, or had the potential to result in, harm to people who lived at the home. Regulation 10 (c) (i) The registered person did not regularly seek the views of people who lived at the home, persons acting on their behalf and staff employed at the home. Regulation 10 (e) The registered person did not have an effective complaints system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, pursuant to Regulation 19 (1) The registered person did not provide service users and those acting on their behalf with support to bring a compliant or make a comment, where such assistance was necessary. Regulation 19 (2b) The registered person did not ensure that all complaints made were fully investigated. Regulation 19 (2c)

The enforcement action we took:

We have served a warning notice to be met by 3 November 2014