Shaw Healthcare Limited

Rotherlea

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 July 2016 and was an unannounced inspection.

Rotherlea provides accommodation and care for up to 70 older people, some of whom are living with dementia. At the time of our visit, there were 61 people in residence (27 in the three downstairs units and 34 in the four units upstairs).

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

There were not enough staff employed by the service. Although the registered manager had mostly maintained the staffing numbers by using temporary staff, this was having an impact on the care that people received. Staff were under pressure and had little time to engage with people socially or to support them to pursue their individual interests. Staff were 'borrowed' from the domestic and activities staff teams to provide care to people. This had a knock on effect on the cleanliness of the home, the ordering of supplies to the kitchen and the provision of activities. Due to staff changes and staff moving between the units of the home, people did not have the continuity of the same keyworker to ensure their wellbeing.

Risks to people's safety had not been managed effectively. We could not be sure that people received appropriate support at all times to minimise any impact on their health.

Medicines were not managed safely. A new electronic recording system for the administration of medicines had been introduced but some staff had not received training to use it effectively. Stocks of medicines did not tally and staff did not always follow the provider's policies in how to store, administer and dispose of medicines.

The Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found the provider was not meeting the requirements of DoLS because the registered manager had not applied to authorise the deprivation of liberty for some people using the service. Staff had a variable understanding of the Mental Capacity Act 2005 (MCA). Records did not demonstrate that people's rights had been protected when they were deemed to lack capacity to make decisions regarding their care and treatment.

Staff did not feel supported by management or that their contribution was valued. Staff had not always received appropriate training, support and supervision to enable them to carry out their duties effectively.

The registered manager had not carried out regular audits to monitor the quality of the service and to make improvements. She told us that she had been working hard behind the scenes to implement an action plan

agreed with the provider. We saw that the score resulting from audits by the provider had improved during 2016.

People's care had been planned but the monitoring in place did not demonstrate that people's planned support had been consistently delivered. People were referred to healthcare professionals to promote good health. Visiting professionals told us that staff generally made appropriate referrals and followed their recommendations.

People enjoyed the food and were offered a choice of meals. Staff did not use any visual prompts to support people living with dementia to understand the choices available to them. We have made a recommendation regarding adaptations to better meet the needs of people living with dementia.

People spoke highly of the regular staff team that supported them. They told us that they were very kind and that they worked extremely hard. They told us that staff treated them with respect and were mindful of their privacy. Some people were actively involved in planning their care, others told us that they would like to have more of a say.

People felt safe at the home. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

People felt able to raise any concerns and had confidence that any complaints they made would be resolved.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were not enough staff with the necessary skills and experience to meet people's needs safely.

Risks to people had not been monitored effectively.

Medicines were not managed safely.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

The service followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received appropriate training, support and supervision.

People's rights may not have been protected because the registered manager was unable to demonstrate that they had acted in accordance with the Mental Capacity Act 2005 (MCA).

People were offered a choice of nutritious food and drink.

The service made contact with health care professionals to support people in maintaining good health.

The premises were purpose built and had been adapted with consideration for people's needs.

Is the service caring?

Requires Improvement

The service was generally caring.

People spoke fondly of the staff that supported them and said they were very kind.

Some of the care we observed was task-based and staff did not have time to engage meaningfully with people.

There was a keyworker system in place, but staff were regularly moved to other units within the home, which did not foster building strong relationships.

Some people felt actively involved in their care, while others told us they would have liked more input.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a lack of meaningful activities for people. There was limited opportunity for people to engage in activities or to enjoy outings.

People's care had been planned and documented but the delivery of care was not suitably monitored.

People felt confident to raise any concerns or complaints but some issues, such as with staffing and a lack of outings, persisted.

Is the service well-led?

Requires Improvement

The service was not well-led.

Communication between management and staff was poor. Staff did not feel supported, listened to or valued.

People and staff told us that they would like to see more of the registered manager. Some people told us that they did not know the registered manager.

Audits designed to monitor the quality and safety of the service had not been completed.

The registered manager understood her responsibilities and had notified the Commission of any incidents in a timely way.

Rotherlea

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 July 2016 and was unannounced.

Two inspectors, a pharmacist inspector and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, we reviewed two previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for ten people, monitoring records, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, handover records, the service-user guide, accident records, audits and minutes of meetings. The home used eMAR (electronic Medical Administration Record) charts. We looked at eMARs of eight people receiving their morning and lunchtime medicines and three printed versions of the eMARs on the ground floor. We looked at the records of prescribed creams administered to12 people and two people's care records, relating to their medicines.

During our inspection, we spoke with 14 people using the service, seven relatives, the registered manager, four team leaders, seven care assistants (including one bank and one regular agency worker), the activities coordinator, the chef on duty and a representative of the provider. We also met with five community nurses and a minister who were visiting the service and asked them for their views. We requested and received feedback from the clinical nurse lead for the area, an admissions avoidance matron, a community psychiatric nurse (CPN), two GP practices, the pharmacist who supplied the home and the home's

hairdresser. They consented to share their views in this report.

Rotherlea was last inspected in June 2014 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

The central concern of people that we spoke with, their relatives and staff related to the staffing pressures at the home. The general feeling was that there was not enough staff to support people safely. Although the registered manager used the services of agency staff to maintain staffing numbers, feedback we received was that there was a high number of temporary staff who did not always understand people's needs or provide effective support.

People were complimentary about individual staff but said there were simply not enough of them. They told us that they had to wait for staff to respond to their call bells. One person told us, "Half the time they haven't got the staff". They told us that staff could not provide the necessary support to everyone, without someone having to wait for assistance. Another said, "If I couldn't walk to the bathroom I'd probably fill my trousers". This person told us that they had waited half an hour that day to be assisted from the toilet and back to their chair. A relative said, "Sometimes they are very short, people seem worried about the situation". The call bell system generated data on the time taken to respond to call bells but we did not analyse this as part of the inspection. The registered manager told us that this would be reviewed in the case of an incident or complaint. There was no ongoing monitoring of the time taken for staff to respond to people's call bells when they requested assistance.

We observed that staff were hard working and busy attending to people's needs. They did not appear to have time to stop and chat with people. Staff told us that they tried to maintain a presence in the communal areas so that they could minimise the risk of people falling. During our SOFI observation of the Easebourne and Henley units in the morning, we saw that staff were often absent in communal areas because they were attending to people in their rooms or the bathroom.

Staff felt under pressure. They told us that, although temporary staff were used to fill gaps in the staffing rota, this did not fully relieve the workload as they required instruction and supervision. One staff member said, "Half don't understand because they are agency workers and overseas. We end up doing it ourselves. I asked agency staff to make tea once and he didn't understand, so I did it myself". A community nurse told us, "Last week there were so many agency, you could feel the tension". We looked at the rotas for the two weeks preceding our inspection. We noted that of the eleven support workers on the day shift, on some days four to six of the team were from agencies. On the night shift, nine of the 14 night shifts had more temporary than permanent support workers. One night there was just one permanent support worker on duty, in addition to the team leader. One person told us, "At night our own local ones are OK but agency are slow coming to see you". Although the registered manager made every effort to use agency staff who knew the home, the high use of temporary staff impacted upon the consistency and quality of service that people received. This was because agency staff were not as familiar with people's needs and routines.

We found that the lack of competent, skilled and experienced staff was having an impact on the care that people received. Further analysis of the rotas revealed that one shift each week had run with one member of care staff fewer than the planned staffing numbers. The care staff numbers on two shifts had been achieved by using staff whose main employment was in other roles, including domestic and activity staff. We were

assured that these staff had received the necessary training to be able to do this. A team leader told us, "If at handover you are fully staffed, there is a round of 'high fives'. I know (registered manager) is doing everything possible". A support worker said, "There has been a drastic change (for the worse) in how many staff have left in the last couple of months. The staff that have left have a lot more experience".

The borrowing of staff from other staff teams, such as the domestic team, within the home was having an impact on these areas of the service. We observed that some parts of the home were not clean and tidy. Some toilets had not been cleaned and some bathroom bins were overflowing. A support worker told us, "Cleaning is appalling and sometimes it smells. It's all gone downhill. There should be two cleaners, but sometimes there's only one and you have to call them on to the floor". They added, "I had to do the bathroom yesterday. There was soiled laundry on the floor and split bags (red bags used for soiled laundry). The smell was awful and it came through to the lounge. I told the team leader, but I don't think much was done about it".

There were insufficient numbers of competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of the staffing concerns at the service. She told us that they were actively recruiting at home and overseas and that free transport was arranged for staff from nearby towns. Contract cleaners were being arranged to carry out a deep clean of the home and then to carry out regular cleaning to maintain standards. In addition, staff had completed diaries of the care some people received to demonstrate that their needs had changed and to discuss their care arrangements with the local authority. The registered manager told us that she was not currently accepting any new admission of people with 'high needs'. By this she meant those who required two staff to assist them with transfers using a hoist. From August 2016, the registered manager told us that the provider had agreed an additional 12 hours a day for a senior support worker. This post would help to support the team leaders on each floor and to increase the number of staff on shift.

Risks to people's safety had generally been identified and assessed but had not always been managed appropriately. Care records contained risk assessments which included moving and handling, falls, skin damage, leaving the building independently and risks associated with people self-medicating. Personal Emergency Evacuation Plans (PEEPs) provided information and guidance to staff in the event that people needed to be evacuated from the premises in an emergency. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. One person told us, "As far as I know, the care I receive is with the risks to me in mind, it's correct".

Action had been planned to minimise risk but monitoring was not always effective. People's risk of developing pressure ulcers had been assessed using the Waterlow scale, a tool specially designed for the purpose. Some people had been prescribed creams to reduce the risk of injury to their skin. We found that the records of these creams being applied contained significant gaps. Although one person's care plan stated, 'All cream charts are to be signed', we found that for a cream prescribed twice daily there were just ten signatures (of 45 expected) for the period of 4 to 26 July 2016. This meant that the person might not have received appropriate support to minimise the risk. Staff used body maps to record any injuries or skin abnormalities, such as skin tears or bruising, identified when supporting people. We found that these body maps had been used a number of times to record different dates and parts of the body. For example, a body map for one person recorded 12 observations that had occurred between 30 January and 11 April 2016. This made the body map difficult to read and unfit for purpose. The admissions avoidance matron told us, "We

have seen an increase in moisture lesions and pressure damage is not reported soon enough". A community nurse also told us, "Pressure damage is not reported soon enough".

Some people's risk assessments identified that they had very sensitive skin. We noted that one person had a large bruise on their arm. Staff told us that this person bruised easily due to medication they were prescribed. When we asked this person how they had hurt themselves, they told us, "A rather clumsy carer rubbed my skin too hard". Prior to our inspection, community nurses had raised concerns regarding the number of skin tears sustained by people at Rotherlea. The admissions avoidance matron said, "They have a lot of skin tears". The registered manager had notified us of two serious injuries in 2016 relating to skin tears; one person required hospital treatment and another had injured their leg when being transferred from their wheelchair.

When people fell, this was recorded and their risk assessment for falls was reviewed. We noted that measures such as sensor mats were in place to alert staff when people in their bedrooms, who were at risk of falling, got up from their bed or chair. This helped staff to support the person and minimise the risk of them falling. One relative told us, "He did have an accident recently when he fell here and broke his hip. He's now on an alarm pad to stop that happening again". Others who were at risk of falling out of bed had bedrails in place or had their bed in a low position with padded mats on the floor to minimise the risk of injury if they rolled out. We found, however, that staff had not always taken prompt action to seek further advice. A mobility risk assessment for one person stated they were at high risk of falls, 'My mobility has deteriorated over the last few months. I am a little unsteady, but walk well with the assistance of one carer and my walking stick'. An 'adverse incident log' for this person recorded they had sustained seven falls, including being found on the floor by staff, between 19 March and 9 July 2016. As a result, the risk assessment had been reviewed and updated; however, there was no record of what action had been taken following the falls. The registered manager told us that action had been taken, including treatment for an infection and replacing the person's slippers but this was not recorded. Following our discussions regarding this person, on the second day of our inspection, the registered manager told us that a referral had been made to the falls team.

There was a lack of detail on how to manage some risks that had been identified. Some people were prescribed 'as required' medicines to support their bowel health and minimise the risk of constipation. We looked at the records for one person who was prescribed an 'as required' laxative and was assisted by staff to use the toilet. We found that the recording of this person's bowel movements was inconsistent. Staff told us that this would be recorded in the daily notes. We looked back over the past week and found that no bowel movements had been recorded. There was no evidence in the care plan that this person's risk of constipation had been assessed, or what action staff should take if a person did not have regular bowel movements. It was, therefore, unclear how staff would be alerted to any problem and how they would know when to administer the 'as required' medicine.

Where staff were concerned that people were not drinking enough and were at risk of dehydration, fluid monitoring charts were maintained. Staff had recorded people's drinks but had not checked that they received enough fluid over a 24 hour period. In the records for one person for the first 18 days of July 2016, just four day's total intake had been recorded. There was no guidance for staff in the care plans for these people as to how much fluid they needed on a daily basis to maintain good health. The lack of guidance on how staff should meet people's need in relation to hydration and the ineffective monitoring meant that people may have been at risk of dehydration. This can have a serious impact on people's health, including putting them at increased risk of urinary tract infections.

The garden required attention and was not safely maintained. Staff told us that the grass was cut regularly,

but the flowerbeds were overgrown and four wooden planters were broken, with soil spilling out onto the ground beneath. An old, disused armchair had been left in one corner of the garden and an upholstered footstool had been left outside. A table had been dumped in another corner. The garden furniture was unpainted and looked uninviting. We observed a couple of people taking a walk in the garden, but some of the tarmac to the paths had split and was broken in places, which was a potential trip hazard. One staff member said, "We've been to staff meetings and we think the garden's dangerous. We have volunteers for the garden, but we haven't seen them for a while". Another member of staff said, "The gardens could do with a bit of attention, they're in desperate need" and added, "It would be nice for the residents to make more use of the gardens". Parts of the garden were unkempt and untidy. One person told us, "It's a lovely view though the garden wants doing".

Arrangements for handling medicines in the home were not always safe. Before this inspection, we received information about concerns regarding the ordering of medicines by the home. This had resulted in people's medicines not being available when they needed them, which could have harmed their health.

The home had changed to an electronic recording system for the administration of medicines four months before this inspection. Staff accessed people's medicines administration records using a laptop computer and used this to record when they had given people their medicines. The system recorded the stock levels of medicines and alerted staff when these were running low. Staff told us that the stock balances on the system were often inaccurate and therefore they could not rely on this to ensure they had enough medicines.

We checked the stocks of seventeen medicines; of these, only three had the correct stock balance on the system. This increased the risk that staff would not order people's medicines in time and they would run out, or that excess amounts of medicines would be ordered. Staff had tried to ensure that medicines would not run out by going through all the medicines and reordering any that would not last until the next monthly delivery. However, staff told us that three medicines had been unavailable for them to give on the morning of our inspection. The registered manager was unable to confirm or monitor how often people's medicines had not been available for them over the past month.

People were mostly happy with how they received their medicines. One person told us, "I am on medication which I get three times a day. They do watch me take them down to make sure that they've gone". Another said, "I get my tablets. Not always at the right time but I do get them". We saw staff giving some people their morning and lunchtime medicines. Staff used a safe and caring method and asked people if they needed medicines, such as those for pain relief or constipation, prescribed to be taken 'when required'. However, we saw that staff recorded that the person had taken their medicines as soon as they prepared them, before they had taken the medicines to the person. This did not follow the home's medicines policy and increased the risk of records being inaccurate.

Medicines were not always stored safely and securely. A suitable medicines storage area was available on each floor of the home. Staff used medicines trolleys to transport medicines around the home. These were stored in a locked room but problems with the keys meant they were not always secured when in use but left unattended. This increased the risk that unauthorised people could access the medicines.

The provider had a medicine policy in place and copies were available for staff. However, this did not refer to the electronic recording system in use at Rotherlea. Staff did not always follow the procedures in the medicines policy for example: the disposal of medicines that people had declined to take, recording minimum and maximum temperatures of the medicines refrigerator and monthly medicines audits. This increased the risk that medicines would not be managed safely.

The failure to do all that was reasonably practicable to mitigate risk and the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us about her plans to address the issues we identified. This included staff training on the eMAR system, a full medicines stock count to correct the information on the system and work to redesign the garden. She anticipated that with the new senior support worker on shift this would help to ensure that monitoring records were maintained and checked to ensure that people had received appropriate support.

Staff we spoke to had a clear understanding of what to do in the event of a medicine error. There was a process in place for reporting incidents involving medicines. A recent mistake had occurred, when someone was given the wrong person's medicines. Suitable action was taken to inform and protect the people involved. The registered manager told us that following this she had secured additional support to help with administering medicines to people on the first floor.

People told us that they felt safe. One person said, "Nothing worries me, I'm happy enough". A relative told us, "I feel (name of person) is safe because the staff are always very kind". Staff had attended training in safeguarding adults at risk. Training records showed that ten percent of staff were due refresher training in July and August 2016. We asked staff about their understanding of safeguarding. One said, "If I see someone's being abused, I'd try my best to stop it. I'd inform the team leader and write a report". A second told us that they felt confident to raise any issues and had the contact number for the local authority safeguarding team in their induction pack. We noted that information for staff on raising alerts and whistleblowing was displayed in the home. The poster read, 'What if it was your Mother? Don't turn a blind eye' and gave instruction to tell the registered manager or to use a confidential email address directed to the provider. The registered manager acted promptly when concerns or allegations were brought to her attention and shared information with the relevant authorities.

Staff recruitment practices were robust. One staff member told us, "They waited for the last reference and then asked me if I can start". Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk. The registered manager reviewed and retained profiles of agency staff and used these to verify that those working in the home were vetted and had received appropriate training.

Requires Improvement

Is the service effective?

Our findings

People were satisfied with the skills of the staff who supported them. One person said, "I do think the care I receive is good and correct. I'm very pleased with it". Another told us, "The staff here do know what they're doing I'm sure. They are very good indeed but could do with more of them; they are certainly rushed off their feet".

Most training was provided via e-learning. This included fire safety, infection control, safeguarding, health and safety and food hygiene. Practical training was provided in moving and handling and fire evacuation. Staff told us that it was not always possible to attend training due to staff shortages. The registered manager said, "Sometimes I have to cancel the training if we can't staff the building". At the time of our inspection, 81 percent of staff had completed the provider's mandatory training topics. Staff who were due refresher training had been identified and courses booked, for example practical moving and handling training for 12 staff was scheduled for August 2016.

Staff did not always receive timely training to support them in providing effective care to people. Staff had not received sufficient training in how to use the home's new electronic medicines recording system. Some staff had not been able to attend the training sessions and had been taught by other staff who attended. Other staff had been on duty during the training sessions and had to dip in and out depending on the needs of the service. There had not been any competency assessments following the training, to make sure staff were able to use the system correctly. The registered manager had not been trained in how to use the new system and was therefore unable to carry out audits of medication and ensure that it was managed safely. We identified concerns with how medicines were managed and found that people did not receive their medicines safely. You can read more about this in the 'Safe' section of this report.

As a result of staff shortages, staff were sometimes asked or given opportunities to work in different job roles, such as support workers in the kitchen or domestic staff providing support to people. On the second day of our inspection, the chef on duty was a support worker who had been keen to train as a chef. They told us that they had completed some shadow shifts with the head Chef but had not received training beyond the basic food hygiene course. The registered manager confirmed that this staff member was enrolled on further training. Staff told us that basic provisions such as biscuits and cornflakes had run out on the units and they were waiting for new stock. One support worker told us, "It's been a good three to four days that we've had limited stock on milk, bread, butter and cornflakes. I've had to say to people, you can't have cornflakes". A person using the service said, "They've been out of cornflakes for almost a week". The provider confirmed that there had been a problem with one food order and advised that additional stock had been purchased locally, although they had been without cornflakes for two days. By the time we visited, stock had been ordered and was due for delivery. The problem had arisen because staff working in the kitchen had not been shown how to complete the food orders.

The service was registered to provide support to older people and those living with dementia. The three units on the ground floor focused on providing support to people living with dementia. The provider's induction included training in dementia care but not all staff had completed additional training in this area.

One staff member who started in March 2016 and worked predominately on the ground floor had yet to receive further training in this topic. On the list of all training provided, we counted 14 staff who had completed a stand-alone course in dementia care; this represented approximately 20 percent of the staff team. People living with dementia have unique needs and further training in this area would ensure staff understood people and were competent in meeting their needs.
We observed one incident where staff might have responded differently to a person living with dementia. The person had taken a walking frame that did not belong to them and a slight altercation ensued with the frame's owner. A team leader intervened and took the walking frame away, swapping the frame for another one. The person became very distressed and upset and said, "I don't want this one, I want my own", believing that the one they had taken was theirs. They hurried in pursuit of the team leader who had taken the original frame. We were told that this person had a history of taking items that did not belong to them. While it was understandable that the walking frame should be returned to its rightful owner, staff could have handled the situation in a more sensitive and reassuring way, without causing so much distress to the person who had taken ownership of the walking frame. Additional training in understanding the experiences of people living with dementia and how to respond to their needs could have resulted in a different response by the staff member. In contrast, other support offered by staff was positive and supported the person's well-being. One relative told us, "The staff do look after him very well, especially (named staff member), she's very good. She knows how to handle him".

Staff did not feel that they received appropriate support from management. One support worker said, "I feel supported by certain members of staff but not by the management". A community nurse told us that staff often came to them with concerns. They said, "The team leaders feel under pressure and unsupported". The provider's policy stated that staff should receive five supervisions and one appraisal each year. We noted that three staff did not have any supervisions recorded in 2016 to-date. A system of supervision and appraisal is important to ensure that staff have an opportunity to discuss their role, their aspirations and any training needs. One member of staff worked as a support worker and as a bank team leader. They explained they received supervision in their role of support worker every six weeks, but had never received supervision to discuss their role of bank team leader, even though they had worked as a bank team leader for just over a year. Support workers had confidence in their team leaders. One said they would go to them with any concerns and added, "She'd sort it out, she does things properly".

The failure to provide appropriate support, training, supervision and appraisal to enable to staff to carry out their duties effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When new staff commenced employment, they completed a period of induction. The home-based induction included orientation to the building, fire, reporting of accidents, reporting safeguarding, clinical waste, records and record keeping, infection control. They then completed a period of shadowing, usually for four shifts (48 hours in total). At the next available date, new staff would attend the provider-led induction, which consisted of four days of training for staff in the support worker role. New staff were required to complete the Care Certificate. The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. One new staff member told us that they had been assigned a mentor and that they had felt supported as they started in their role.

Additional courses were available to staff but some staff told us it took a long time between asking for the training and receiving it. One support worker said that they had asked for training in writing care plans and waited almost two years. They had just recently completed the course. Other staff had completed courses in

catheter care, communication, confidentiality, dining with dignity and person-centred care. Staff were able to complete diplomas in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

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

We checked whether the service was working within the principles of the MCA. People's capacity had been assessed in relation to specific decisions, including their understanding of their need to receive care and support, managing their finances and in relation to end of life care decisions. Some people used sensor mats to alert staff if they got up and hopefully reduce the risk of them falling. In the care plans we checked, people had been able to understand the use of the mat and had consented to having it as part of their care. One person was documented as saying, 'Yes I suppose it's OK if it is for my own good'. We observed that staff asked people for their agreement before supporting them and respected their choices regarding where they wished to spend their day. Where people refused care, this was respected. For example, one person had opted to sleep in their chair for the past couple of nights and another had refused to attend a hospital appointment at the fracture clinic. One person told us, "They do listen to what I have to say, yes, I do have a choice".

Although staff sought people's consent in day to day decisions, people's rights under the MCA were not always protected because some decisions had not been assessed in line with the principles of the Act. For example, one person had a sensor alarm in their bedroom which used a laser to detect movement. There was no evidence that they had been consulted about the use of this technology. When we visited this person in their room we triggered the alarm. A staff member attended and asked us to turn it back on when we left. We explained to the person what we were doing but they did not appear to understand that there was a sensor or its purpose.

Some people had appointed lasting power of attorneys (LPA) to act on their behalf in the event that they lacked capacity. The care plans that we looked at contained information on the people appointed but there were no copies of the authorisations. The registered manager should be assured that the authorisation is valid before accepting instructions from the LPA regarding a person's care or finances.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Providers are required to submit applications to a 'Supervisory Body' for authority to authorise the deprivation of liberty. At the time of our inspection, 12 DoLS had been applied for, three in 2015 and nine in 2016. The registered manager told us, "The majority (of people living at the home) need them doing. The team leaders are doing them". The registered manager told us that she had not set a deadline by which to complete this work. The current understanding on whether a person is being deprived of their liberty followed a ruling by the Supreme Court in March 2014. The registered manager had not taken timely action to ensure that people's rights were protected.

Staff understanding on the MCA and DoLS was variable. Some staff were able to describe clearly how they applied the principles of MCA to their work. One bank team leader told us, "Always presume they've got capacity and can make unwise decisions". They continued to explain about best interests meetings and

least restrictive options. Others however struggled to share the basic principles of the MCA. In the minutes of a team leader meeting from June 2016, one team leader had requested additional support to enable them to complete DoLS applications. We read, 'I don't know how to do it and you are always too busy'. The deputy manager had offered additional support. There were examples in care plans which demonstrated a lack of understanding, for example it was recorded that one person had, 'No capacity' but there was no assessment to show how their capacity had been measured, or in relation to which particular decision. The lack of staff understanding regarding the MCA meant that people may not have been fully involved in decisions relating to their care and that their rights may not always be protected.

The failure to act in accordance with the MCA and to ensure that care was provided with consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were satisfied with the food provided at the home. One person said, "Meals are lovely and you get things you like". Another told us, "The food is varied, sometimes it is awful, sometimes it is really nice". A third said, "The food could be 'tarted up'; you get the same thing over and over". People were asked for their dietary preferences when they moved to the home and the menu was discussed at residents' meetings. In the afternoon, we observed staff asking people what they wanted to eat for their lunch and supper the next day and being given options from the menu. People confirmed that they were able to ask for an alternative if they changed their mind once their meal had been served. We observed that people living with dementia were also asked in advance for an advance choice of meal. As people living with dementia often have short-term memory loss they may not have remembered the food choices they made by the next day when they sat down to eat their meals. Staff did not use visual references or picture menus to aid people's understanding of the choices on offer, either at the time they made their meal choices or at the table where they ate their meals.

Staff monitored people to ensure that they maintained a healthy weight. Most people were weighed monthly and their risk of malnourishment was assessed using the Malnutrition Universal Screening Tool (MUST). A dietary assessment had been completed for each person and included information about their eating and drinking, nutritional status, hydration, dietary requirements and eating and drinking skills. Staff supported people who required assistance to eat. Where people had lost weight, staff had taken action, such as by fortifying meals (to boost the calorific value), recording what and how much the person had eaten, weighing them more frequently and making referrals to other professionals such as the dietician. We observed a team leader supporting one person who had not been eating well over the past few days. She asked the person what they fancied to eat. They said they would like a soft-boiled egg, which was provided. Throughout our inspection, we observed that people had drinks within reach. One person in their bedroom told us, "As soon as it's empty (jug of juice) they fill it up again". Another said, "There are plenty of snacks available throughout the day, lots of liquid by way of tea, coffee, water and juices if you want them".

People were supported to see healthcare professionals. One person told us, "The doctors will come in if needed. The staff will arrange it". Another said, "I saw the optician a few weeks ago and they would arrange for the doctor if I wanted". Care records documented people's visits and involvement with healthcare professionals. This included appointments with GPs, district nurses and opticians. A member of staff said they would notice when people were unwell and would report this to the team leader, so that appropriate support could be sought. The staff member gave an example that if a person's behaviour changed they might test their urine to find out if they had an infection. A team leader told us, "When you know the residents you know the signs". Healthcare professionals shared their experience of supporting people at Rotherlea. They told us that if they spoke with an experienced team leader, their recommendations were followed up effectively.

The premises were purpose built and provided spacious accommodation. Corridors were equipped with handrails to make it easier for people to move around. The ground floor of the home had been decorated and furnished with attention to the needs of people living with dementia. The main corridor, referred to as, 'The Street', had various items or furniture or reminiscence areas. For example, one part of The Street had a patch of artificial grass on which stood a wicker chair and an old-fashioned telephone booth. There were two upright pianos and a football game. Some people had memory boxes on their bedroom doors which contained items or photos of importance to them. Signage had been used to good effect, providing written and visual references to aid people as they moved around on the ground floor. One relative had written to the staff saying, 'Thank you for making Rotherlea such a nice, colourful place for my husband and other residents'.

Requires Improvement

Is the service caring?

Our findings

People spoke kindly about the staff who supported them. One person said, "I love them all! I think they're brilliant! Everything they do for you they do with love, you can tell". Another told us, "I think all of the staff are very affectionate and very caring. They cuddle you if you're upset to cheer you up". Some people expressed concern for the staff saying that they worked very hard. One person said, "The ones we've got are very nice but they can't do any more. They do their best". Relatives were complimentary. One told us, "The staff seem caring and thoughtful". Another said, "Most of it's been very good. Some of the staff are friendlier than others". Other relatives had written to express their thanks. In one card we read, 'Thank you for all the thoughtful things you have done for him. You are all a very caring, hardworking team'. In another, 'It was so comforting to know that each and every one of you were so caring towards her when we had to leave'.

We observed that staff were generally warm, patient and kind with people and supported them in a caring way. They knelt beside people when supporting them and offered reassurance. We observed one staff member gently stroking a person's hand and speaking gently to them. One person had become anxious and said they wanted to leave. A support worker sat down with them and spoke to them kindly, suggesting they should have a cup of tea before they left. This reassured and relaxed the person, and the cup of tea had distracted them from leaving the home at that moment. A second support worker told us about their role saying, "I really enjoy it. I'm comfortable here and I know what I'm doing. I've made friendships with people. You go shopping for them and you help them". We saw that care records contained 'life maps' for people, which included information on their relatives, holidays, hobbies, friends, memorable life events, employment, childhood, dreams and wishes. Staff told us that this information was useful and helped them to engage with people on subjects that interested them.

The staffing challenges at the home did not support staff in fostering strong relationships with people. One person told us, "I don't have any regular staff; they do seem to change quite a lot". Time pressures meant that many of their interactions with people were task-based. They had little time to spend chatting with people or engaging socially. A keyworker system was in place. This meant that each person had an allocated staff member who co-ordinated all aspects of their care. The intention was that the keyworker really got to know the individual people they were linked to and ensured that they had everything they needed. Some people seemed unsure as to who their keyworker was or said that it had changed. Staff confirmed that the people they were linked to as keyworkers often changed, due to staff leaving or staff moving to work on different units within the home. One relative told us, "I can't find anyone free to have a word with. I don't understand the chain of control. They are all very amenable but I don't know who to see. It's been a bit like groping in the dark". Although a system was in place, it was not working effectively to improve people's experiences.

People shared mixed views about involvement in their care. One person told us, "They certainly do interact with me to make decisions about my care. They chat with me, we talk it through and then decide what needs to be done". Another said, "They don't seem to pay that much attention to what I have to say, not as much as I'd like. Having said that, they don't do anything that I don't want them to". Some care records contained information on whether people wanted their next of kin to be involved in decisions regarding

their support. Others had signed their care plans and risk assessments to demonstrate their agreement. Throughout our inspection we observed staff as they provided support to people. Most of the time staff actively supported people's involvement in making day to day decisions regarding their care. On occasion, however, the delivery of care appeared task-focused and did not give consideration to individuals.

We observed the lunchtime experience for people in the Lodsworth unit and carried out an observation using the SOFI tool. Meals were transported from the kitchen to each unit on the ground floor on a heated trolley. We observed people sitting at tables, which were laid with tablecloths, placemats, with a vase of artificial flowers on one table. We heard one person ask a member of staff what was on the menu for lunch, to which the response was either beef stew or jacket potato. The person said they would like to have jacket potato. A short time later, the heated trolley was wheeled into the dining room and one member of staff was dishing up beef stew. The other member of staff picked up one filled plate and asked, "Who's this for?" and the response was, "Everyone has the same one". Meals were put down in front of people and the person who had asked for jacket potato was given beef stew. Glasses of blackcurrant squash were placed by each place setting, which may have been people's preference, but no-one was asked what they would like to drink. There was little social interaction between people and staff; conversations were task related. We heard one person say, "I don't like the runner beans, they're not cooked enough for me", but this was ignored by staff. There was a lack of warmth or friendliness and staff were not always responsive to people's comments and did not engage with them in an approachable manner.

By contrast, we observed a support worker asking people if they would like to see the chiropodist who was visiting the home that day. The staff member spoke to people in an encouraging way. They said, "What do you think? It's up to you. I'll come with you". At lunchtime, in the Minsted unit, staff were attentive and cheerful. They were available if people needed support and reacted quickly. At handover staff were told, '(Name of person) had a little lie in this morning, she didn't fancy getting up'. We observed staff supporting people to be as independent as they were able. One support worker said, "Most people in this unit take themselves to the toilet. I always ask people if they want help and I do check on them". Another support worker talked about independence and said, "I'd explain to them fully what they needed to do to keep regular personal hygiene. Give them a flannel, get them to wash their face first and keep them as independent as possible". A team leader explained how they were supporting one person to maintain their mobility. They explained that, following the person's suggestion, they supported them to use their frame in the morning but used a wheelchair in the afternoon when they tended to feel tired.

It was clear through our observations during the inspection that there was a great deal of variation in the caring and person-centred approach of staff, which was an area requiring improvement.

People told us that staff treated them respectfully. One said, "They are very respectful, never ever been rude to me. They're always polite and friendly, they are my friends!" Another told us, "They do respect my privacy, because they knock and wait for me to invite them in. They also preserve my dignity as far as they can. I'm not shy about that at all". A third shared, "They do treat me with the greatest of respect". Our observations confirmed that staff were generally considerate and attentive to people. When we asked staff how they ensured people's privacy, they told us, "I make sure they've got a towel over them and explain what I'm doing". We observed that staff placed a screen around the community nurse when they were changing a person's leg dressing. This ensured they were given privacy in the sitting room. The registered manager told us that the home had appointed three dignity champions. This was a new initiative whereby staff would be offered additional training and given the role of encouraging best practice within the staff team.

Requires Improvement

Is the service responsive?

Our findings

People told us that they would like more to do. One person said, "There's only so much television you can watch". They added, "I went on one trip to the seaside, nothing before or since". Another told us, "It makes it so much better if they (staff) talk to you but they've got too much to do". A third said, "We would like some outings. It's gone down. There are not many things to do. I've not been out for nine to ten months". During our visit we observed very little activity or stimulation for people. Many people were asleep as they sat in chairs in the lounge areas, although some were supported by staff to read the newspaper or to complete a puzzle.

Two activity staff worked at the service and activities were planned each week. The programme for the week we visited included a coffee morning, pet therapy, a visiting singer, hairdressing and bingo. We found, however, that activities did not always take place as planned. This was due to staff shortages and activity staff supporting in other parts of the home. One activity coordinator told us, "The activity is the first thing to go when there is no staff. There aren't enough of us". They added, "We're getting spread so thin. I can't guarantee a week that we've put up (the schedule) will happen". In the week of our visit, the activities planned for Monday and Wednesday had been curtailed. This was because the activity staff had been needed to accompany a person to hospital and to run the day care facility.

Staff had gathered information about people and their interests. This had been used to support some people with specific activities. For example the activity coordinator had gathered information and pictures for one person about their favourite singer, four others had been out for a drink at a local pub. Another six people had been out for lunch, supported by volunteers from a local college who visited the home weekly during term-time. There was also a system for people to 'Make a wish', which staff would try to fulfil. The activity coordinator told us that they were planning to facilitate the wishes some people had expressed, but that this had not yet been possible. Other people had not been able to enjoy their hobbies. For example, we read that one person 'loved gardening'. When we asked this person whether they had been out in the garden, they told us, "There's no one to go with".

Involvement in activities can help to give people a sense of purpose, reduce loneliness and improve self-esteem. People living with dementia often require additional support to initiate and engage in activities. We found that there were not always sufficient numbers of staff to meet people's emotional and social needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information about people and how their needs should be met by staff. This included details on their preferred day and night routine as well as specifics on areas of their care such as support they needed with communication, mobility, managing pain and dressing. Some people told us that they were actively involved in planning their care. One said, "I did set up my care plan with them and they make adjustments as we go along". Others told us that their family took care of this. One person told us, "I wasn't involved with my care plan; I think the family helped the staff with it. It's updated on an ongoing basis as far as I'm aware". Some people had expressed their wishes regarding future care, including where they would

wish to be cared for at the end of their lives and who they would like to be with them.

People told us that staff considered their preferences when delivering care. One person said, "They do listen and try to do it how you like it done". Another told us, "I don't like the dark so they leave my bathroom door slightly ajar with the light on just to give me a little bit of light. That's caring!" A relative said, "I've asked them to give her a whisky every night which she gets and really enjoys". Staff did their best to respond to people's needs, although there was sometimes a delay as they were busy supporting other people.

The shift handover record included relevant information such as changes in a person's medication, updates on referrals to other healthcare professionals and people who required additional attention due to concerns. For example staff were asked to monitor one person closely as they had not eaten much, another person was due to receive a new frame to aid their mobility but required supervision to reduce the risk of them falling. A third person was having ear drops, they were not wearing their hearing aids and staff would need to speak clearly to them. Lastly, staff were reminded that it was one person's birthday and were encouraged to, 'Go and sing to her'. A CPN told us that if they shared information on a person's treatment with an experienced team leader, the information was handled efficiently and acted upon. There was, however, a shared view among the healthcare professionals that information was not always shared effectively within the staff team. One GP practice wrote, 'It is not unusual for the GP to have to make several telephone calls to different members of staff at Rotherlea about the same patient and the same problem'.

We found that most care plans contained up-to-date information that reflected people's current needs. A team leader explained that care plans were, "Meant to be done (reviewed) every month. Some are and some aren't". We noted that some information, while noted in the review, had not been updated in the body of the care plan. This might mean that key information was missed. For example, we read that one person used a urine bottle during the night but they had in fact been using a catheter for approximately ten months. A representative of the provider told us a new format of care plans was due to be introduced. One staff member had attended training regarding the new care plans. They were enthusiastic about the new format and said that it guided staff through exactly what information and documentation was required.

The system to monitor the care that people received was not effective. This meant that care that was planned to meet people's needs may not have always been delivered. Staff completed daily notes regarding the support given to people and how they had spent their day. This information varied from day to day, for example some staff included that they had bathed or showered a person or that they had assisted them to shave. Others did not. It was, therefore, difficult to monitor that all of people's planned needs, such as bathing and oral care, were being met. The community nurses had raised concerns regarding the incidence of sore groins and moisture lesions, which might be preventable with careful attention to personal care and hygiene. Although there were columns on the handover sheet to document checks on monitoring information, including for food, fluid and topical creams, these had not been used. We saw that the registered manager had written to staff in May 2016 regarding this. We read, 'I am concerned that you are not ensuring residents who are on food and fluid charts are receiving adequate amounts. There is no evidence that every team leader is monitoring this'. At our inspection, we found that this remained an issue. You can read more about the monitoring of risks in the 'Safe' section of this report.

People were able to share any concerns with staff. One person told us, "If they hear me grumble about something they are quite fast in sorting me out". Resident and relative meetings were held every two months. Although some issues had been raised, people did not always feel that these had been resolved. This related specifically to concerns around staffing, outings and the garden. One person told us, "They did listen. They haven't done anything but they listened". When we asked another person if changes had been made they told us, "Not a bit!" A relative said, "There is always the subject of staffing but the answer is

always the same; 'they're recruiting'. Some of the staff are on their knees, they have too much responsibility and too much to do". We knew from our conversations with the registered manager that she was aware of people's concerns in these areas. The registered manager had approval from the provider to increase by one the staff working on the day shift and was using a variety of methods to recruit new staff. You can read more about this in the 'Safe' section of this report.

People knew how to make a complaint and told us they would feel confident to do so. One person said, "I haven't complained about anything yet but, if I needed to, I'd probably talk to one of the carers and get them to take it further for me. I'm sure something would be done if I did complain". Another told us, "I have complained about things, nothing too serious though. It was all sorted quickly". Information on how to make a complaint was displayed in the home. It was also included in the service user guide, which most people had copies of in their rooms.

We looked at a sample of the complaints that had been received during 2016 to see how they had been addressed. We found that registered manager had followed the provider's policy and that action had been taken to reduce the likelihood that the same issues would arise in future. For example, one relative had complained that their relative had received poor care during a respite stay and that their creams and painkillers were untouched following the stay. As a result, further training was offered to bank team leaders regarding admissions to the home. Following a complaint about the food, staff had met with the person to discuss their preferences. A relative had since written to the registered manager saying, 'This is a most encouraging response and we really appreciate all the effort that has gone into making (name of person's) meal needs well catered for… It is very reassuring for us to know that you have very quickly put a system in place that will meet her needs'.

Requires Improvement

Is the service well-led?

Our findings

The system to assess, monitor and improve the quality and safety of the service had not been operated effectively. The schedule of monthly audits required by the provider had not been completed. We saw that audits of medication, the environment, infection control and catering had not been completed since 2015. During our inspection, we identified concerns in these areas. For example, parts of the home were not clean, some bins were overflowing and a storage room for equipment was unlocked, presenting a potential risk to people. The registered manager told us that she did a daily 'walk around' of the service but these checks were not recorded.

The electronic medicines administration system used at Rotherlea allowed a variety of reports to be run so that staff could audit the use of medicines in the home. However, staff told us they did not know about these reports. The registered manager had not received any training on the system and was not able to run any reports to check that people had received their medicines correctly. No medicines audits had been completed since the new system was introduced, four months before our inspection. The registered manager was not able to assure herself that people's medicines were available when needed and administered safely.

When accidents and incidents occurred, these were documented by staff and reviewed by the registered manager. The registered manager was aware of her responsibilities to notify external agencies, including the Commission and did this in a timely way. A system was in place to review accidents and incidents on a monthly basis with a view to identifying any trends so that action could be taken to reduce the likelihood of future harm to people. These audits had not been routinely completed. In 2016 to-date, two of the expected six audits had been completed. This could mean that risks to people's health and safety would not be identified and addressed promptly.

The registered manager was in the process of seeking feedback from people and their relatives as part of the quality assurance processes at the home. Questionnaires had been sent out to ask for people's views on the service. The registered manager told us that these were sent twice a year, but the results of the last survey were not available for us to view. One relative told us, "I've never been asked for feedback but I do think that they are open and honest here".

The system to monitor the quality and safety of the service and to ensure compliance with the regulations was not operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had completed a quality audits and the actions identified were being addressed. The registered manager showed us the two previous quality audits carried out by the provider team. We saw that the score had improved from 78 percent in March to 83 percent in May 2016. The registered manager told us that the January 2016 audit had recorded a score of 53 percent. The areas of concern identified during this inspection had been highlighted by the provider's audit and were included in an action plan. For each action, a responsible person and deadline for completion had been agreed. The registered manager told us,

"I'm aware the home is not where it should be and I'm working on it. Things are going to improve especially with the go ahead to get a new senior support worker in place and the push on staffing to reduce agency and take the pressure off".

The registered manager had not carried out any audits to determine whether the service was meeting the needs of the people they supported. We noted that improvements could be made to improve the choice and control available to people living with dementia. For example, visual prompts and aids could be used to good effect to promote choice regarding menus and activities. Further staff training in meeting the needs of people living with dementia could equip staff with the skills to communicate effectively and resolve possible conflicts between people using the service. We noted that some actions were planned to make improvements, for example the registered manager planned to order new coloured crockery which might help some people's visual perception of their meals and encourage them to eat more. We recommend that the registered manager consider the ways in which the service could be further adapted to meet the needs of people living with dementia.

Staff told us that the morale in the home was low. Many said they felt under pressure and undervalued. One staff member said, "When you come to work, you think, 'What am I going to be facing today?'". Another told us, "I haven't had a thank you in the whole time I've worked here. I feel appreciated by the residents and other staff members but not by management. When you pick up an extra shift there is never a 'thank you'". A third, when asked if they would recommend the home told us, "Probably not. Just the way things are run or if a resident wants to do something, we can't always make sure that can happen. Staff morale is low". Some relatives expressed concerns. One said, "It used to be a happy place and the residents were more contented. It worries them and they shouldn't have to worry". They added, "There are mutterings in recent months, there is discontent. Why are so many good workers leaving? That's the question".

The communication between management and staff was not effective. Although the registered manager was aware of the concerns in the staff team, staff did not feel they had been listened to. They were not aware of the work the registered manager was doing to make improvements. Staff meetings were held for seniors on a monthly basis and for all staff every two months. One staff member told us, "In all honesty I've stopped going because of everything we've brought up, nothing has been done about it". Another said, "(The registered manager and deputy) never come on the floor, even when we are desperate. They say come to us if we are struggling but what is the point if they're not going to do anything about it?"

We asked care staff if they thought the home was well led. One staff member said, "I hardly ever see the registered manager on the floor. She knows some of the residents, but not all". Another member of care staff said, "It feels like the management don't care, they don't bother and everyone's struggling". We asked them whether they felt they could discuss their concerns with the registered manager and they said, "I wouldn't go to her with a problem. She never comes on the floor. There's no encouragement, there's just orders". We asked a third member of staff whether they felt supported by the management. They said that the registered manager "Comes out every now and again and usually walks around every day. She doesn't know all the residents by name". Our conversations with people using the service indicated that the registered manager was not well-known to them. Three people told us that they did not know her name. One person who had lived at the home for more than a year said, "I don't know the manager's name or her or him by sight".

The registered manager had been in post since the home opened in 2008. Prior to this inspection, she had been seconded to work in another of the provider's services and returned to Rotherlea in December 2015. A deputy, who had joined the home in 2015, supported the registered manager. The registered manager told us that there had been a number of issues on her return and that her focus had been on improving the service. She told us, "I haven't kept up. There is too much to do. I know the home still isn't where it was when

I left it". She added, "Staff are probably not seeing enough of us. I've not spent as much time on the floor as I've been working to bring the home back. I've been holed up doing things behind the scenes".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with consent of the relevant person. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people. The provider had failed to do all that was reasonably practicable to mitigate risks to people. The provider had failed to ensure that the premises (garden) were safe for use. Medicines were not managed safely. Regulation 12(1)(2)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure compliance with the regulations. The system to assess, monitor and improve the quality and safety of the service and to mitigate risks to health and safety had not been used effectively. Regulation 17 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient suitably qualified, competent, skilled and experiences staff to meet people's needs. Staff had not consistently received appropriate support, training, supervision and appraisal to enable them to carry out their duties effectively. Regulation 18(1)(2)(a)