Mr Roger Daniel

Red Rose Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22 and 24 May 2018; the first day of inspection was unannounced.

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

Red Rose Nursing Home accommodates up to 65 people across three separate units. One unit provides care for people living with dementia, another provides care for people with nursing care needs, and a third provides care for people who have residential care needs. At the time of our inspection 45 people lived at Red Rose Nursing Home. The manager told us, although they had vacancies across all units, they were specifically not accepting any new admissions on to the nursing unit. This was because they wanted to ensure improvements identified at our last inspection had been achieved.

At our comprehensive inspection in December 2017, we rated the service was 'good' overall. In response to further information of concern received, we completed a responsive comprehensive inspection in January 2018 and we rated the service as 'Requires Improvement.' We found four breaches of the Health and Social Care Act (Regulated Activities) Regulation 2014, and issued three requirement notices and a warning notice telling the provider to improve. At this inspection we found the required improvements had not been made. This was the provider's third inspection in 10 months.

Risks associated with people's care needs, such as those associated with the use of bed rails, and from refusals of personal care were not well managed. Assessments of people's health and care needs were not consistently in place and care plans were not always up to date and comprehensive. Accidents and incidents, such as falls, were not analysed and used to help identify how to reduce the likelihood and make improvements. People did not always receive timely referrals and reviews of their care when their needs changed or their care and treatment had become ineffective.

Risks associated with the premises, such as the regulation of water temperatures to reduce the risks associated with scalding were not effectively managed. The facilities on the nursing unit did not fully meet people's needs as people had to use showers on other units within the building.

Infection prevention and control practices did not protect people from the risks associated with infection. Cleaning products and thickening powder were not stored securely.

Guidance for medicines given when people needed them, rather than at set times, did not contain sufficient detail to ensure they were administered consistently. Not all creams had dates of opening recorded and thickening powder prescribed for one person was used for another person.

Staff were not competent to provide care in line with some people's care plans as they had not been trained

to safely hold people. In addition, competency checks on staff were not always completed and many staff had not completed the training identified by the provider as required for their role. Many staff did not have the level of training required to care for people with the assurance that they did so with appropriate levels of skill, knowledge and understanding. This included staff knowledge on how diversity and equality issues may affect the people they cared for. Staff supervisions did not prompt staff to complete their training.

There were not enough staff deployed to meet people's needs in a timely manner, and to provide people with emotional support when they needed it.

Staff did not always check people's consent to care before they provided it, and assessments and provision of people's care had not always followed the Mental Capacity Act 2005 (MCA). Staff knowledge on the MCA and DoLS varied and staff did not always understand how this legislation applied to the people they cared for.

People enjoyed their food, however they did not always receive food that met their preferences. People's privacy and dignity was not always maintained and promoted. People's personal care needs and people's needs associated with their anxiety or behaviours that challenged, had not always been met in a personalised and responsive manner. Staff did not always use language that showed empathy for people and their care needs. There was a lack of meaningful activities for people to enjoy.

People and most relatives were not involved in the development and review of care plans.

Responses to complaints had not been made in line with the timescales in the provider's complaints policy.

Actions to fully meet the accessible information standard were not always in place to provide assurances people's communication needs would be met.

People had care plans in place for when they required care at the end of their lives; however, some arrangements were not clear.

Systems and processes designed to assess, monitor and improve the quality and safety of services, and reduce risks were not effective. Records were not always kept securely. A registered manager was not in place; however the manager had taken steps to begin the process of registration with the CQC.

Views gathered from people, relatives and staff did not cover a breadth of issues to help inform the development and improvement of the service. Statutory notifications had not always been submitted as required.

People told us they felt safe with the staff that cared for them, however not all staff were knowledgeable about how to follow procedure in order to safeguard people. Staff recruitment included pre-employment checks that helped the provider make judgements about the staff employed to work at the service. Staff told us about some steps they took to promote people's dignity and privacy and people's independence was supported.

Assessments under the deprivation of liberty safeguards (DoLS) had been applied for when identified as required. Referrals to other professionals had been made, however not always consistently. People could access other healthcare services, such as their GP when needed.

The design, adaption and decoration of the dementia and residential unit had been used to help meet

people's needs.

At this inspection we found eight breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not always well managed and people's care needs were not consistently assessed. Steps to reduce the risks associated with medicines and infection prevention and control were not consistently in place. Sufficient staff were not available to meet people's needs. Not all staff had been trained in safeguarding people and other competencies required for their role had not been developed and checked. Incidents were not analysed sufficiently to inform improvements.

Is the service effective?

Inadequate

The service was not effective.

There were shortfalls in the level of training and competency checks on staff for them to perform their job role. Staff did not always seek people's consent to their care and did not always understand how the MCA and DoLS applied to people. Decision making did not always demonstrate it had been taken in line with the MCA. Not all aspects of the premises met people's needs. People had access to healthcare services, however referrals for reviews of people's care from other professionals had not always been made in a timely manner. People were provided with food and drink, however this sometimes did not meet their preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care that met their emotional needs, promoted their dignity and respected their privacy. People and families were not involved in the development of care plans. People's independence was supported.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were not always met in a personalised and

responsive manner. Complaints had not been responded to within the timescale set by the provider's own policy. People had care plans in place when they needed care at the end of their lives, however some aspects of this care were not clear.

Is the service well-led?

Inadequate

The service was not well-led.

Systems and processes were not effectively operated to ensure the quality and safety of services and to reduce risks. Statutory notifications had not always been submitted. Attempts to involve and engage people, relatives and staff had been taken, however they were not always effective. Systems to promote continuous learning and development were not always effective. The manager was in the process of registering with the CQC to become a registered manager.

Red Rose Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 22 and 24 May 2018; the first day of inspection was unannounced. The first day of inspection was completed by two inspectors and a specialist professional advisor, whose area of specialism was nursing. The second inspection day was completed by one inspector.

Before the inspection visit we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

As this was an inspection to follow up on the actions we told the provider to take at our last inspection we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took the information from the PIR completed by the provider in 2017 into account when we inspected the service and made the judgements in this report. We also gave the provider the opportunity to update this information during the inspection.

We spoke with the local authority and health clinical commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. We also checked what information Healthwatch Nottinghamshire had received on the service. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

In addition, during our inspection we spoke with five people who used the service. We also 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 spoke with ten relatives. We also spoke with the registered manager, a representative of the provider, three nurses, two senior care staff, three care staff, a

maintenance person, two domestic staff and the receptionist.

We looked at the relevant parts of seven people's care plans and reviewed other records relating to the care people received and how the service was managed. This included risk assessments, quality assurance checks, staff training and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2018, we found one breach of Regulation 12 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider did not have systems and processes in place to ensure safe care was provided. The provider sent us an action plan with details of how they planned to improve. At this inspection we found improvements were still required, and we found continuing breaches of Regulation 12 and 18.

Some people used bed rails to help reduce the risk of them falling from bed. Bed rails require an assessment to ensure they are both suitable for the person and the bed and mattress they are fitted to. The manger told us there was no assessment process used to assess whether they were safe for people to use. For example, some people living with dementia may be restless at night and the use of bedrails may create more risk of entrapment. In addition, the manager told us there had been no maintenance check on the bedrails in use, which were a mixture of integral bed rails as well as telescopic bed rails. Bedrails require careful management and as such they should be regularly checked to ensure they are in good working order, correctly and safely positioned and that other risks associated with their use are minimised. People were not protected from the risks associated with bedrails as no initial assessment was completed and no regular maintenance checks were in place. Risks to the health and safety of service users had not been assessed.

We saw one person had a care plan and individual risk assessment for 'sleeping' and this included their use of bed rails. However, it stated the person often tried to get out of bed at night, lift their legs over the side of the bed rails and place their feet on the floor. These actions had not been recognised nor assessed as potential reasons to not use bed rails. The previous six months of monthly evaluations of their 'sleeping' care plan contained entries of the person continuing to be restless, sleeping crossways in bed, putting their legs out of bed and trying to climb out. An incident form recorded the person had climbed over the bed rails and was found on the crash mat. None of these actions had been recognised as, nor assessed as, potential contraindications to their use. Another person had bed rails in place however their care plan for sleeping did not mention the use of bed rails and nor was there any individual risk assessment in place. Their sleeping care plan stated they had a diagnosis of dementia and had confusion and disorientation and found it difficult to sleep. This meant there was also no monthly evaluation of whether bed rails were suitable for their care and were not presenting risks. People were not protected from the risks associated with bed rails as incidents and potential risks associated with them were not being properly considered. Not all actions to reduce risks had been taken.

Staff we spoke with told us, "Some people get aggressive with personal care." One person's daily notes stated they had been safely restrained by trained staff whilst they provided personal care. The manager told us this restraint was in the form of a hand hold. There was no care plan or risk assessment in place on how to safely hold this person. Staff had not been trained in how to use safe holds on people. The daily notes for this person recorded nine incidents of aggression towards staff since 3 February 2018 however, there was no care plan or risk assessment in place to guide staff on how to manage any incidents of aggression. We discussed this with the manager who was unaware of the incident of recorded restraint. The manager had previously told us no physical restraint was used in the service and staff had not received training for such

use. We made the manager aware this incident may need to be reported as a safeguarding referral. Another person did have a care plan in place for staff to hold their hands during personal care. It stated, 'Two staff may be required, one staff holding the person's hands while another person washes them.' We made a safeguarding referral for these two people as we received no confirmation from the manager they had referred them to safeguarding. Staff did not have the competence and skills to care for people safely.

We saw other assessments for people's health and care needs and associated risks were in place; however, these were not always consistently in place. For example, one person was cared for in bed and was at risk of pressure ulceration due to a number of indications. The care plan referred to a 'waterlow' chart, however there was no evidence of this in their care plan. A 'waterlow' score is an assessment tool that gives an estimated risk for the development of a pressure sore in a person. There was also no comprehensive assessment of the person's mobility. Another person had refused aspects of their personal care. There was no risk assessment in place to assess the risks presented to the person from their refusals. This meant risks in relation to people's health conditions were not consistently assessed and monitored.

Care plans did not always provide comprehensive, coherent and up to date information on people's needs. For example, one person's communication care plan made reference to the person having Parkinson's disease. However, this was the only reference to this health condition in the whole care plan. Their care records also had information on type two diabetes; however, there was no reference to diabetes's in their food and nutrition care plan or nutrition passport. Additionally, their skin care plan stated they needed a pressure cushion and air flow mattress to help prevent pressure ulceration. These were not in place and the manager told us their pressure area had now healed. Their care plan had not been updated. People were at risk from not receiving appropriate care as their care plans were not always up to date and did not always reflect their health care needs.

Staff told us, and records confirmed any accidents, incidents and near misses were reported. However, there was no systematic analysis of certain types of incidents, such as falls. There were 10 un-witnessed falls in communal areas between 9 April 2018 and 22 May 2018; in addition there were another six falls where people had fallen in their own bedrooms. The manager told us these had not been analysed to see if any trends could be identified that would help to reduce falls. For example, a review of the time of day and where staff were at the time of each fall. Systems were not in place to help identify learning from incidents and to identify improvements.

One person's monthly evaluation records showed for the three consecutive months prior to our inspection their medicine given for anxiety and behaviour that challenged had not been effective. No referral had been made to review and consider other options to help the person experience more positive outcomes. People did not always receive an assessment of their needs when they changed or when care and treatment was no longer effective.

There were concerns with infection prevention and control processes. We observed a staff member putting clean laundry away. The laundry dropped onto the floor and the staff member proceeded to put it away. In addition, clean laundry was balanced on top of a cleaning trolley and some of the laundry was directly balanced over the red bag area. Red bags are used in care settings to collect and separate dirty items and keep them separate to clean items. We asked the staff member about their practice and their training and they told us they were just covering as the laundry team was short staffed. We were not assured the staff member understood about the correct protocols for infection prevention and control. Practices were not followed by staff to ensure people were protected by the prevention and control of infection.

Most of the communal toilets were clean; however, we did find one toilet seat riser to be rusty and so we

were not assured it could be effectively cleaned. We found gaps on the cleaning rotas and so were not assured all cleaning was completed as required. One person told us, "My biggest concern is the laundry; the person who has been doing the laundry is leaving and now we have been reminded to make sure that everything has our room number on it until a new person is in place and they get to know whose clothes are whose." The manager confirmed some temporary arrangements were currently in place to cover the laundry duties.

Some people were prescribed medicines to take when they were needed, rather than at any specific time. Some of these medicines were prescribed for people living with dementia when they experienced behaviours that challenged or for when they became anxious. However, we found the guidance for staff to follow on when to administer these medicines did not specify what strategies should be tried before the medicine was administered. Another person was prescribed medicine if they were in pain, however the guidance for staff did not include how staff were to identify if the person was in pain. This meant there was a risk staff did not administer people's medicines in a consistent manner.

In addition, we saw staff use a tub of thickening powder prescribed for use with one person, to thicken a drink for another person. We also found topical medicines, such as creams had not always been dated when opened. There are recommended disposal times from when topical medicines are opened to ensure they remain effective. When dates of opening are not recorded staff do not know when to dispose of the medicine. Medicines were not always managed safely.

Staff with responsibility for medicines understood the processes for ordering, storage and disposal of medicines. Most staff with responsibility for administering medicines had been trained in medicines administration and management; however, records showed nine out of the 12 staff who administered medicines were out of date with their annual medicines competency observation. Observations of staff competency help to ensure staff are competent in their roles and understand the provider's medicines policies and practices. Not all staff had been assessed as competent to administer medicines.

The Health and Safety Executive states water temperatures must not exceed 44°C for people living in care settings who are at risk from scalding from whole body immersion. On our inspection visit we found the temperature of one bath ran at 54°C and another bath ran at 48°C. Historic maintenance checks on water temperatures had recorded temperatures of up to 46°C. We shared our concerns with the provider who sent us further maintenance record checks shortly after our inspection. These also showed water temperatures for a bathroom had been recorded as above the recommended safe temperature for two consecutive months prior to our inspection. The provider told us one temperature monitoring value (TMV) was broken and one required adjusting. Effective action had not been taken to regulate water to temperatures recommended as safe for people using the service. The premises were not always safe for people.

Other aspects of the premises were not being used in a safe way. For example, outside of the building we found an accumulation of excess building materials adjacent to a fire door. We also found a self-closing fire door to the ironing room was prevented from closing as it was obstructed by two containers of coat hangers. This meant not all actions to reduce risks from fire and safe evacuation were being taken.

The door to a staff office on the dementia unit was open during our inspection visits. Inside the staff office was an unlocked and open cupboard with cleaning materials and food and drink thickening powder. In addition, we found a cleaning trolley with cleaning materials on it had been left unattended in a communal toilet. Cleaning substances and thickening powder present a risk to people living with dementia from ingestion and should be kept secure at all times. Actions to reduce risks to people had not been taken.

In addition, the provider failed to ensure staff were competent in their roles. We observed a 'low pressure' warning light on a person's pressure mattress. Staff were not able to confirm the correct setting for the pressure mattress or how they would check the setting it was on was correct. We observed staff covering laundry duties did not follow good practice guidance. Not all staff were competent in their roles.

Other training courses required checks on staff competency; we found these were not always completed on all staff. Out of the 11 staff who had been identified for a check on their medicines competency, only 3 of those were recorded as having an in date competency check. Only 22 staff were listed as having their competency checked for moving and handling; some of the dates for these checks were in 2014 and 2015. Only 12 staff had competency checks recorded for their understanding of safeguarding.

The manager identified 22 staff on the training matrix who worked in the dementia unit. Only four staff were recorded as having completed either of the two dementia training courses identified by the provider as required for their role in 2017 or 2018; eight staff had not been trained in the provider's dementia training at all. The provider had not taken sufficient steps to ensure staff had the skills and competence to provide safe care for their role.

The provider failed to ensure that people received care that was assessed as safe, where risks were identified, monitored and reduced; and where care was provided by competent and appropriately skilled staff.

This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they felt there were enough staff. However other people and their relatives told us of incidents of when they experienced poor care due to staff not always being available. One person told us they did not feel there were enough staff at weekends, however in the week there was usually enough staff.

The provider's representative told us they used a staffing dependency tool to provide an estimate as to how many staff were required to meet people's care needs. However, staff we spoke with had little confidence this was helpful. This was because the staff told us the estimates of staff needed never seemed to change. In addition, staff told us they felt the dependency tool did not allow them to include the needs of people who were living with dementia.

Six relatives expressed concerns with either staffing levels or how staff were deployed. One family member told us, "I am concerned about the staffing levels. Three staff are not enough when the majority of people require two staff for any interventions. [One staff] is left being limited to what they can do. This causes delays in care. My relative was still in their nightwear at 11.00am today." Another relative told us, "Weekend staffing is bad, usually only two plus a senior. [My relative] gets put to bed too early and at night they often have to wait for their care if they need staff to come to them. At one time people used to be getting ready for bed at 3.30pm that was too early; we've not see that recently." They added, "Staffing levels are not enough. Staff need to work in pairs to assist people but there are only three staff at any time." A third relative told us, "There are not enough staff here, and the staff that are here are too busy and don't really know what they are doing; staff come and go. Staff start to get some experience and then go elsewhere. No-one stays here very long. The care they give at best, shall we say, lacks finesse." A staff member also told us their views on why staff did not stay. They said, "Staff leave because of the pay; if they paid just a little bit more staff wouldn't leave only to go to another home." Another staff member told us agency staff did not know people's needs. They said, "We have fewer people but they have high [care] needs; I make representations that we need to have regular staff."

On our inspection visit we saw one person was very distressed. They were walking alone and then came to sit and talk with us. After a short while one staff member was in the vicinity and passed them a tissue and offered for them to walk round with them as they did their jobs. The person declined as they were too upset. We asked the staff member if any other staff members were available to sit and chat with the person and offer reassurance; they told us everyone else was busy. They then left to carry on with their other work. The person continued to sit with us. They sat with us for a total of 15 minutes before a staff member was free and was able to offer them a cup of tea and a chat. This meant staff had not always been available to provide emotional reassurance to people when needed.

On our first inspection visit the manager told us they had double booked an agency nurse and they were having to revise the rota to arrange cover. We also saw the manager had identified on a daily walk round record, dated 1 May 2018, that they were short staffed in one unit and needed to look at staffing across the home. The action that had been identified was to move a carer from the dementia unit onto the nursing unit. There was no consideration of the impact this would have on people living on the dementia unit.

Staff consistently told us they did not feel there were enough staff. Staff told us of days when the numbers of staff did not match what had been planned on the rota. We found a recent example of this which meant the numbers of staff calculated as required to meet people's needs had not been met. Staff told us the manager would work if there were staffing shortages. We spoke with the manager and they confirmed they had recently had to come in and work on the rota to ensure the service was staffed. Staff told us how not having sufficient numbers of staff meant people's needs were not always met. One staff member told us, "I can't walk round with [name] if we are short staffed." They told us being able to walk round with this person helped them manage their condition. Other staff told us, "We've not had enough staff here on duty this afternoon; I've not been able to go home," and, "There's only the senior and two staff up here; that's why people are waiting for their tea; and then there aren't enough staff to answer the call bells or to take people to the bathroom when they want the toilet. It will be better at 6 o'clock because another staff member comes on to help people get ready for bed." They added, "The personal care is not proper when [we are short of staff]. People don't get a bath or a shower they only get a quick wash, just the essentials. It's not right for personal care to get cut short just because we don't have enough staff." They finished by saying, "Activities get cut when we don't have enough staff. We have to prioritise delivering the care and so the activities get cancelled so that the activities staff can provide the care."

Our observations showed people in one unit waited for 30 minutes for their midday meal to arrive and waited for 40 minutes for their evening meal to arrive after being seated in the dining areas. One person told us they did not mind waiting for their meal as they enjoyed looking out of the window. However, they told us the wait for their meal often meant they needed the toilet during the meal time and would have to wait for staff to be able to assist them. There was insufficient numbers of staff deployed to meet people's needs.

Although staff knew steps were being taken to recruit new staff they told us they needed to get to know people. One staff member told us, "Today for instance, two staff working [on this unit] have only worked here for two weeks; they just don't know people well enough to be able to care for them properly." There were insufficient numbers of competent staff to meet people's needs safely.

The provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were available to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines are subject to additional controls and we found these were in place as required. Medicines were stored securely and records showed when staff had administered medicines.

People told us they felt safe when staff provided them with care. One person told us, "I'm well looked after here and feel very safe." Most staff had been trained in safeguarding, however not all staff we spoke with demonstrated they were competent in their understanding. For example, we asked staff whether they could talk to the local authority directly about any concerns they had over people's safety. They told us they did not think they were allowed to go to the local authority with any concerns. The local authority is the lead agency for any safeguarding concerns.

We reviewed staff recruitment files to check all the required pre-employment checks had been completed. Nurses are required to register with the Nursing and Midwifery Council (NMC); they are issued with a personal identification number (PIN) that confirms they are registered and fit to practice. We found the manager had recorded details of nurses' PIN's and these were within date. We found pre-employment recruitment checks had been completed for the recruitment files we looked at. However, a photocopy of one staff member's identity documents had not been retained on file. Pre-employment checks had been completed on staff to help the provider make a judgement on whether staff were suitable to work at the service.

We saw risk assessments were in place should people be required to evacuate the premises. These recorded what support people would require in the event of an emergency evacuation.

Inadequate

Is the service effective?

Our findings

At our previous inspection we found one breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because arrangements were not in place to ensure that where people had their liberty restricted this was in their best interests. The provider sent us an action plan with details of how they planned to improve. At this inspection we found improvements were still required, and we found a continuing breach of Regulation 11.

Staff did not always check people consented to their care before they provided it. One person told us staff had told them where they would sit for their meals. Our observations of mealtimes showed staff did not always check if people wanted to wear any clothing protection while they had their meal. In one dining room staff were seen to walk around and place an apron on people without asking them. Care was provided without people's consent.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had policies in place that covered the MCA and making decisions in a person's best interests. Where appropriate, applications for DoLS authorisations had been made. The care plan of one person, who lacked mental capacity, stated their family member had given permission for staff to hold a person's hands during personal care. For another person who lacked mental capacity, an incident form showed when the person had fallen from bed, the use of bed rails had been discussed with the person's relative. The record stated the relative agreed to the use of bed rails. For both people, there was no further information to say if the relatives held any legal authority to make such a decision and there were no records to show a best interests' decision had been held. The MCA regarding personal care did not specifically refer to the fact the person's hands may need to be held by staff. There was no mental capacity assessment and best interest decision for one person who used bed rails. When people lacked the mental capacity to make some specific decisions by themselves we found the principles of the MCA had not always been fully upheld.

Staff we spoke with did not always demonstrate they understood how the MCA and DoLS related to the people they cared for. One person told us no one had a DoLS in place. Another staff member did not understand what conditions were in place when people's DoLS had been authorised. Another staff member told us, "I don't really know much about capacity, I haven't had the training yet." People's consent to their care and treatment had not always been sought in line with the MCA, staff knowledge on how to care for people who lacked capacity was limited and staff did not always seek consent from people to their care.

The provider had failed to provide care with people's consent; and when people did not have the mental capacity to consent to their care, the provider had failed to provide care in line with the principles of the MCA.

This is a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were induction records for agency staff that covered an introduction to the building and the main systems used. However, not all these areas had been recorded as having been completed. For example, we saw nothing had been recorded to say an agency staff member had been shown the fire procedures. Another agency staff member's induction record had not recorded they had received information on the building security. The provider could not provide assurances agency staff received a full and complete induction to the service before starting work. This meant staff may not always have the skills, experience and knowledge for their job role.

The manager showed us a training matrix that listed 64 staff who were required to complete training the provider had identified as required for their role. The manager told us they understood this training should be refreshed annually. However, some staff we spoke with told us they had not completed all of this training. One staff member said, "I've completed the Care Certificate, infection prevention and control and health and safety; but I had no induction, just one night of shadowing; I use a stand aid but have had no moving and handling training, no safeguarding training." Another staff member who started work at the service recently told us, "The induction was poor, lots was happening on that day and there wasn't the time; I've done training since and got to know people." Not all staff had support and training needed for their job role.

Out of the 64 staff on the training matrix, only 10 staff had completed training on the duty of care and care principles, only 21 staff had completed person centred care, and only 20 staff had completed handling information and record keeping. One staff member told us, "Because we don't have enough staff we can't release staff to do their training; if the staff don't do their training it's not safe." Staff were not supported and trained to ensure they were competent in their job role.

Thirty two staff were recorded as having started their Care Certificate training. The Care Certificate aims to ensure care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care. Only six of those staff were recorded as having completed their Care Certificate. The Care Certificate is expected to take on average, 12 weeks to complete. Ten staff who had not completed the Care Certificate were over the 12 week timescale; some of these were a considerable time over the 12 week period having started it over two years ago. We asked the manager why not all staff had completed the Care Certificate; the manager told us some staff had lost their workbooks. This meant staff were not supported and managed to obtain the skills, knowledge and competence required for their job role.

In addition, one person had a care plan in place that stated staff may have to hold their hands during personal care to prevent them hitting out at staff. We also found staff recorded on an incident form that they had safely restrained another person. The manager told us no restraint took place at the service and staff were not trained in safe holds to use on people. However, the provider's own records indicated restraint was being used. The provider could not provide assurances staff were competent to safely hold people during care as they had not been trained.

One person told us staff were, "Very good," when trying to understand people's needs. Most relatives told us their confidence in whether staff understood their relations' needs varied depending on which staff were

working and how long they had worked at the service. One relative told us, "Some days it is all new staff that do not know our [relative] very well." Another told us, "Weekends are especially bad; I dread bank holidays as I've not seen a staff member I recognise."

Staff told us, and records confirmed they were not always trained in areas relevant to people's care needs. Some staff told us they had received supervision with the new manager and records confirmed this. Supervision is an opportunity to provide staff members with the chance to reflect and learn from their practice, receive personal support and professional development. However, we did not see that supervisions discussed with staff had prompted them to become up to date with the training that was required of them. In addition, some senior staff told us they had not been able to give staff supervision. They told us, "We are supposed to give supervisions, but there isn't the time to give them; it's a busy place here, we never stop, there's lots to do." The service had not provided staff with the skills, knowledge and experience they needed to deliver effective care and support.

The provider had failed to ensure staff had the skills, knowledge, experience, training and support for them to fulfil their job roles competently.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nursing unit had no en-suite shower rooms, instead it had two communal bathrooms. One had been refurbished to include a wet room, however the other bathroom was limited in the facilities it offered. For example, it had a fixed height bath that may not be suitable to people's needs. One family member told us, "The bathrooms are inadequate and my relative hadn't had a bath since their admission over [x] years ago." On our inspection visit we observed a person being assisted from the nursing unit to access a shower on the residential unit. Staff told us there was no shower that could be used on the nursing unit and so they worked with staff on the residential unit in order to access the showers. Staff told us this meant there were times people needed to wait for the shower room to be free downstairs for them to have a shower. Some family members also told us the hairdressing room became unbearably hot as it did not have adequate ventilation. They also told us not all dining rooms had hand washing sinks installed for staff and people to use during meal times. Some people's needs were not met by the adaption and design of the premises.

The design, adaption and decoration of other units did meet people's needs more. For example, the dementia unit made use of design and decoration ideas considered to help people living with dementia. Adaptions, such as handrails to aid people with their mobility were fitted where needed in the property. Areas where there was an identified risk, for example, the kitchen and laundry were kept secure. People's rooms were personalised and people had a choice of different areas to sit within the home.

People or relatives did not raise any concerns with us about people being treated unfairly or being discriminated against. Staff we spoke with had varying knowledge about people's diverse needs, including people's religious beliefs and how they were met. Some staff knew that some faith organisations visited the service and some people met with them when they did. Only 28 out of 64 staff on the training matrix had been recorded as having completed training on equality and diversity. Some of the training dates recorded included 2011, 2013 and 2014 and so had not been currently refreshed. Care plans assessed people's needs associated with any disability, however there was less information on what care was needed to meet any other needs associated with protected characteristics such as religion.

People told us they enjoyed the food; however, we observed people did not always receive food that met their preferences. Relatives had mixed views about food. One relative was happy with the food and knew

their relation was given fortified drinks to help combat weight loss. One relative told us there was now fresh fruit provided in the lounges and the kitchen staff would make alternative meals if that was preferred. However, other relatives felt the food choices could improve and be more varied and imaginative. One relative told us they felt the budget for food had been recently reduced and they were disappointed in the quality of the food. They said, "There is no fresh salad and they use things like tins of spaghetti." Most relatives told us they were not worried about weight loss. One relative said, "[My relative] must be eating well because their weight has increased to a healthy level." The manager monitored people's weights for any weight loss and had identified people when they required any fortification of their nutritional intake.

Other assessments of people's care needs were mostly in place, for example in the assessment of falls risks. Where people required specific assessments associated with their health conditions such as referrals made to the dementia outreach team and speech and language therapists; we saw referrals had been made, however this had not always been done consistently for people. Assessments helped to achieve effective health outcomes for people.

People's healthcare needs were assessed and they had access to other healthcare professionals when needed. One person told us, I can see may doctor whenever I need to, the staff will arrange this for me. I was really happy that I could keep my own GP when I moved here as they have known me for many years." One relative told us the GP had changed their relations medicines recently. They also said, "[Name] had their eyes tested at the opticians last week." Records showed other healthcare professionals visited such a chiropodists. People were supported to access healthcare when needed.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we rated the service 'requires improvement' in response to the question, 'Is the service caring?' This was because we found some care practices did not always ensure people's privacy and dignity was promoted.

At this inspection, our observations showed people were still not always supported to maintain their dignity and privacy. For example, some people used showers on a separate unit to the one their bedroom was located on. We observed staff assist one person to use the showers on a different unit. After their shower staff assisted them back upstairs; however, the person was still wet from the shower and they had only been wrapped in towels; staff told us this was so the person could get dressed in their room. We did not consider this provided the person with sufficient privacy and dignity. People had not always been treated with dignity and respect.

We observed another female person whose buttons on their dress were undone. This exposed their underwear. During staff interactions with this person we did not see staff ask whether they could assist the person to adjust their clothing or notice this was an issue. We observed a staff member put a sequinned hat on a person living with dementia. We spoke with the staff member as we felt the person may not have chosen to wear that style of hat. The staff member told us it probably would not have been that person's choice; however they were trying to brighten their mood. We did not feel this showed sufficient respect for the person's preferences. Several staff referred to assisting people with their meals as, "Doing the feeds." We did not feel this demonstrated staff showed sufficient empathy for the care people required. People had not received care that promoted their dignity and treated them with sufficient respect.

The provider had failed to ensure care and support was provided in ways that promoted people's dignity and privacy and provided people with sufficient respect.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

One person told us, "The staff are all very caring." Relatives had mixed views on whether staff were caring. One relative told us, "I have no qualms staff are caring." However, another relative told us, "[Staff] don't talk to a lot of the people." Staff spoke fondly of the people they cared for. For example, one staff member told us, "I love my work and seeing these people smile makes my day."

Staff told us about the steps they took to maintain people's privacy and dignity. For example, one staff member told us, "I always make sure I close the door or windows and curtains if ever I am supporting people in their rooms. We have signs that we can use to put on the door if we are giving people care in one of the bathrooms; this stops other staff bringing people in."

People and most relatives we spoke with were not familiar with a care plan. One person told us, "There must be a care plan; I can only imagine it's very complicated but I've never seen it." One relative told us they had

been involved in providing information on their relative's life history and was involved in their care plan. However, all the other relatives we spoke with told us they were not involved. Two relatives told us, "Care plans? We've never seen them, we had no input into the care plans; we didn't help write them, we weren't asked for any input and are not involved in reviewing them." Care plans we reviewed showed some relatives had been involved in some aspects of their relatives' care plans, however this was not always consistent.

People told us they were supported with their independence. For example, one person told us, "The staff always encourage me to do as much as I can for myself." Relatives told us they were able to visit people freely. People's independence was respected and relationships with people's families and friends were supported.

The service paid operated a 'resident of the day' programme. We saw this day included the 'resident of the day' having their room deep cleaned, being offered their favourite food, doing something they enjoyed and having a chat with the manager.

Requires Improvement

Is the service responsive?

Our findings

Some people told us there was not a lot to do while living at Red Rose Nursing Home. One person said, "By the time I get out of here I'll have telly-itis, as there is not much to do." Most relatives we spoke with shared the view that there was little for the relatives to do. One said, "There is no stimulation here." Another relative told us, "It's got worse in terms of activities." We saw people had been asked what they would like to do and these had been placed on a 'wish tree'. The manager told us they were hoping they would be able to support people to do the things they wanted, however, they told us there had been an unexpected delay to the activities coordinator starting work. No other staff member had been identified to cover the absence of the activities coordinator.

Staff shared the view that there were few opportunities for people to become involved in meaningful activities. One staff member told us, "Activities get cut when we don't have enough staff; we have to prioritise delivering the care and so the activities get cancelled so that the activities staff can provide the care." Another staff member told us, "I suppose there are enough staff to keep people safe, but not enough staff for people to have a good quality of life." Staff told us more meaningful activities were only provided if they had time. For example, one staff member told us, "One person enjoys gardening. If we have time we will bring in some pots for them to plant up or sit with them and look at the garden and talk about it. We also put the gardening television programmes on TV for them; that makes them feel part of the household here and at home."

We observed one staff member used a book to engage a person in discussion. We also saw one person went to have their hair done. However, for other people on the dementia unit we observed they remained asleep and the only interactions with staff were when they were offered a drink or were informed it was lunch time. Staff had recorded they spent 'one to one' time with people most days. Some of these records showed staff knew people, for example one had recorded they spent time with a person chatting about the holidays they had taken. However, there was no indication of how long these 'one to one' times lasted for.

People's choices and preferences were not always met. One person told us they had enjoyed their meal; however, they told us they had asked for chicken but had been given cauliflower tart. They said, "If those were chicken fillets, then they were the strangest chicken fillets I've ever seen; and I've never seen chicken fillets on a pastry base before!" They said staff had told them they had ran out of chicken. We saw the person asked staff for a second drink. They told us their cup was small and they found they needed a second cup. The staff went to get the drink; however the staff member did not return. The person told us staff often 'forgot' to bring them a second drink. We saw the pudding choice was ice cream on one of our inspection days. We asked staff what the alternative was and they were not able to tell us. People were not always supported with the food and drink that met their preferences.

Some relatives told us they were concerned that their relations were not getting a regular shower or the personal care they needed. One relative told us, "Staff told me there was not time to shower [my relative] last week; so they were not going to get one." They told us they were not satisfied with this and spoke with another staff member who helped and they told us, "[My relative] did get a shower eventually." Another

relative told us they felt their relation was not taken to the toilet when they needed to; they said, "I still feel [name] is being left to get wet." An action plan from a relatives and residents meeting in April identified concerns had been raised over people not having regular baths or their hair washed. In addition, the manager told us about a person who had not received a shower since they started living at the service. They told us this was because the service had not got an appropriate shower chair to use. A relative we spoke with also told us their relation had not had a bath since their admission. People did not always receive care that was appropriate and met their needs.

We looked at people's personal care records. In the dementia unit we found people's names on a 'shower list.' This listed two people per week day who were to receive a shower; four people were identified as needing a bed bath every day. Whilst records of actual showers given showed people did not have showers on set days, these indicated that for two out of the three people's records we looked at, people did not have a shower more frequently than usually once a week. We also looked at the records staff made when they had provided care for people to clean their teeth. These showed many gaps. For example, records were not in place to confirm a person had their teeth cleaned on 14 days for the month of our inspection. The provider could not always provide assurances people received the personal care they needed. This meant people were at risk of receiving care that was not always appropriate and met their needs and preferences.

Incident records showed some people were repeatedly anxious, sometimes at specific times, such as during personal care and could show behaviours that were challenging. Staff completed incident forms which were intended to identify any triggers to behaviours that challenged, what the behaviour was and what staff did to manage the situation. For one person, we saw their incident forms recorded 'reassurance given to no effect' had been recorded on four separate occasions in the month before our inspection. The person's care plan listed several strategies to help care be provided without triggering any behaviour that challenged. These included, playing music, having just one staff member speak, staff avoiding conversations between themselves, try again at another time, try different staff and offer reassurance. The incident forms did not demonstrate what aspects of the care plan had been followed and which strategies had or had not worked. Whilst we saw a referral had been made the following month to external health professionals and some potential health causes had been considered as contributing factors; there was no analysis of what strategies in the person's care plan were not working. As such, we were not assured this person had always received responsive and personalised care. Care and treatment had not always been appropriate and met people's needs and preferences.

We saw there was an automatic clock with the date and time on it in one of the dining areas. Whilst this as accurate, another handwritten sign on a noticeboard was not; it stated 'Today is Sunday 20th May.' The day was Tuesday 22nd May. This could introduce confusion for people living with dementia. This was not appropriate care for people living with dementia.

The provider failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation.

This is a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

People and families told us they knew how to complain should they need to; however relatives were not assured of a robust response. One relative told us, "I wrote to the owners last September but I have not had a reply." The manager told us there was not a record of all the complaints received about the service since our last inspection. However, they did tell us they were in receipt of three complaints and a response to them was overdue. We requested details of the complaints received to be sent through to us and the

provider sent us this information. Not all of these had received a final outcome letter within the timescale set by the provider's complaints policy. Sometimes people had not had a final outcome letter for some time. For example, complaints dated the 14 and 20 March 2018 had outcome letters dated 5 June 2018. In addition, the provider's complaints policy advised people if they had not received an outcome within 28 days they could contact the Parliamentary and Health Ombudsman. However, it is the Local Government Ombudsman that deals with all adult social care organisations, including care homes. The provider's complaints process was not being completed within the timescales advised in the provider's policy; the provider's complaints policy did not direct people to the appropriate ombudsman service if they were dissatisfied with how their complaint was managed.

We asked the manager what actions they had taken to meet the accessible information standard. The accessible information standard was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. The manager told us they were not familiar with this standard. However, they told us if people required information in large print for example, this could be arranged for them. Whilst we saw care plans were in place for people's communication needs, we did not see how this had been extended to assess what format people would require information in. For example, information such as the complaints procedure and their care plan in order to facilitate their involvement in it.

People who received care towards the end of their life had care plans in place. We saw these detailed any anticipatory medicines that may be required for pain relief. People's wishes, such as whether they wished any family members to be present were also recorded.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found one breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued a warning notice telling the provider to become compliant with the Regulation by 19 March 2018. This was because the provider had failed to respond effectively when continuing concerns were raised about service quality, and in particular had failed to monitor the quality of the service. At this inspection we found improvements were still required, and we found a continuing breach of Regulation 17. We also found a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our inspection visit, the manager told us they were not accepting any new admissions onto the nursing unit. This was because they wanted to the improvements required from our last inspection.

At this inspection, the provider had not adequately assessed whether bed rails were suitable for people to use. The manager told us there was no initial screening tool. This is an assessment tool used to assess whether a person's health conditions, physical size and behaviours may create a risk to them using bed rails and prompt them to look at lower risk alternatives. In addition, the provider did not monitor the use of bed rails and complete regular maintenance and safety checks on them. This is important because unless bed rails are correctly positioned and remain in good working order and are fitted correctly, they pose a risk of entrapment to the person using them. The provider had also failed to review the use of bedrails when incidents that indicated potential increases in risk to their use occurred. Systems and processes to assess, monitor and mitigate risk were not effectively operated.

Checks on the health and safety of premises had failed to identify potential risks. Maintenance records of water temperatures for the Willow bathroom showed the temperature had been recorded at 52°C in April 2018 and continued to be recorded as exceeding the safe temperature recommendation in May where records showed this had been recorded at 51°C. This monitoring had not resulted in the risk from scalding being reduced as the temperature had not been limited to within the recommended safe temperature limit. The Health and Safety Executive (HSE) states water temperatures must not exceed 44°C for people living in care settings who are at risk from scalding from whole body immersion. During our inspection visit we tested the water temperature of two baths and found the water temperature for both exceeded the HSE's advice; the temperatures were recorded at 48°C and 54°C. The provider had failed to assess and mitigate the risks from scalding when their assessment in April and May showed water temperatures exceeded the safe recommended temperature by the HSE. In addition, checks on the safety of the premises on the day of our inspection visit had not identified an accumulation of excess building materials adjacent to a fire door; nor that a fire door was obstructed from closing. Risks to people were not always reduced.

The manager was not able to show us any infection prevention and control audit. They told us this had been completed by the personal assistant to the provider. They were unable to confirm this person was suitably knowledgeable in infection prevention and control to complete the audit. As the manager had not seen any completed infection prevention and control audits they were unable to tell us whether any actions had been identified for improvement. We found continued failings with infection prevention and control at the service.

The provider had failed to ensure cleaning materials were kept securely in accordance with industry requirements. These are the 'control of substances hazardous to health regulations 2002' (COSHH). This was because we found cleaning products were not always stored correctly and had been left in places accessible by people using the service, including people living with dementia. We found equipment had not always been identified when it became rusty and therefore required replacing as it was unable to be cleaned effectively. We found some staff did not follow good practice guidelines when storing clean laundry. The systems and processes designed to assess, monitor, improve and mitigate risks from the risk of infection were not effective.

We found staff training and competency checks in areas the provider had identified as required for their role had not been completed by staff. Staff competency checks in areas such as safeguarding, medicines and moving and handling were not completed for all staff. In addition, the provider had not ensured staff had completed the training they had identified as required for their job roles, nor had they ensured staff who had commenced on the Care Certificate completed this in a timely manner. We had identified the provider's training had not been sufficiently completed by staff at our inspections in December 2017 and January 2018. Systems and processes to ensure staff completed the training identified by the provider as required for their role were not effective.

We found one person's care plan contained guidance for staff on how to restrain them; in addition, we found an incident record where staff had stated they had safely restrained a different person. The manager was unaware restraint had occurred and told us no restraint was used at the service. They contacted the staff member who had left the service for clarification. They told us they had confirmed they had used a hand hold. However, after our inspection visits the provider told us the incident of restraint had not happened. The provider's own records indicated that restraint had taken place. The provider had failed to assess care plans and incident forms to establish what guidance was being given to staff and what staff were doing. The provider had failed to ensure that the care that was planned and the care that was provided was in line with its own views.

The provider had failed to ensure records were kept securely. This was because the office door on the dementia unit was found to be unlocked throughout our inspection. This office contained people's care plans and other confidential personal records. We found care plans were also left unattended on the residential unit. In another unoccupied room we found one person's personal care records from some months previously. In addition, care plans were not always up to date and accurate. For example, one person who used bed rails had no care plan, risk assessment or mental capacity assessment in place. Another person's care plan referred to their waterlow chart, however this was not in their care plan. Another person's care plan did not reflect their health condition. Records were not always accurate and kept securely.

A representative of the provider told us they calculated the number of staff needed to meet people's needs by reviews of such incidents as slips, trips and falls. However, the manager told us there had been no analysis of falls in April and May 2018 where we found a number of unwitnessed falls. After our inspection visit the provider told us this was in place and sent us a 'narrative report on accidents.' This did not identify the number of falls that occurred in communal areas and did not analyse staff deployment at the time of the fall. Therefore, the provider had not provided assurances that they were using evidence of slips, trips and falls to help them calculate the number and deployment of staff as their representative had told us. Systems and processes to help assess, monitor, improve services, and assess, monitor and mitigate risk were not effectively operated.

The provider's representative also told us they used a staffing dependency tool however, other staff who had

tried to use this told us they did not think it worked. Staff and relatives also provided examples of their experiences of staffing and where they thought it could be improved. However, we saw no evidence of how these views had been asked for or considered as part of planning the numbers of staff needed to meet people's needs. Feedback from people, staff and relatives had not been used to improve the service.

The Commission had been notified of an incident where a person who was on an end of life care, and had anticipatory medicines prescribed for when needed, had died an expected death. However, staff had given cardio-pulmonary resuscitation (CPR) when they had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) order in place. The notification stated staff knowledge on DNACPR would be addressed in supervisions. We saw file notes had been added to people's care plans to also clarify. However, the manager told us they felt there was still confusion over what constituted a valid DNACPR between themselves and other agencies, such as the GP and the East Midlands Ambulance Service. We were not assured the manager had fully resolved this issue and were concerned staff had not received a clear message. We raised our concerns directly with the provider after our inspection. They told us they would circulate information from EMAS dated 2015 that stated photocopied DNACPR's were valid unless a person had a reason to believe otherwise. Systems and processes designed to improve services and reduce risks to people were not effectively operated.

The provider had failed to effectively operate systems and processes to assess, monitor and improve services and assess, monitor and reduce risks to people. They had failed to keep accurate and secure records; they had failed t ensure people, staff and relatives views had been taken into account to develop and improve the service.

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

The provider is required to submit statutory notifications to CQC. Notifications are changes, events or incidents that providers must tell us about. The manager told us about an allegation of abuse concerning a person using the service. We had not received any notification for this incident and asked the manager whether they had sent us the required notification. They told us they, "Probably hadn't," and told us they needed to set a file up for safeguarding referrals. In addition, no statutory notifications were submitted following our inspection where we identified some safeguarding issues surrounding people's care. This meant we had not been notified when allegations of abuse had been made concerning people using the service.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Most relatives were not satisfied that the service was well-led. One told us, "We are disappointed in how things are run." Another told us, "Something is fundamentally wrong." Records showed there had been a meeting arranged with relatives. Some relatives told us other meetings had been arranged however, one had recently been postponed due to low numbers of relatives attending. One relative told us, "[The manager] listens, but I am not sure they can change things." Another relative told us the meeting they went to had been attended by the manager but no other representatives from the provider had attended. Whilst a third relative told us, "They have meetings but nothing happens." Records showed the provider had asked relatives for their views on the food; however this survey had not asked people and their relatives about other aspects of quality and safety of services. Whilst some people had been asked for a 'wish' to go on a wish tree, the manager was not able to tell us any of these had yet been met. We did not see people had been asked for their views on their experiences of living at the service.

The staff survey consisted of focussed questions regarding the management structure of the service, who to report a complaint to and whether staff knew about whistle-blowing. Staff were not asked any wider questions about the quality and safety of services. Records showed views of visiting professionals, such as social workers were asked for. Although attempts had been taken to obtain the views of relatives, staff and visiting professionals, the questions were limited and did not always provide the opportunity to gather views on wider aspects of quality and safety of services.

Various meetings with staff took place to organise care. We saw there was a daily stand up meeting to cover with each unit leader what was happening each day. In addition, records showed there were meetings with the 'heads of department'. A meeting on 18 April identified 'no access to activities that meet the needs of residents, life stories to be used to encourage meaningful activities'. They also identified problems with a lack of completed supervisions and poor care documentation. Our evidence also demonstrated a lack of meaningful activities for people and concerns with care records. Despite these issues being identified in a 'heads of department meeting' a month before our inspection we could not see any progress had been made to improve. The service did not demonstrate it had the systems and processes in place to effectively learn, improve and innovate.

A registered manager is required at Red Rose Nursing Home. The manager had applied to become a registered manager at the time of our inspection visit. 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. We saw the CQC's rating for the service was on display as required.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that was centred on them, and care did not meet their needs and preferences and did not provide social stimulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care and support did not promote people's dignity, privacy or provided people with sufficient respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not always provided with people's consent and when people did not have the mental capacity to consent to their care, the care provided was not always in line with the principles of the MCA.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided safely. Risks were not always assessed, monitored and mitigated, there were insufficient staff to meet service user's needs and staff had not been checked to ensure they were competent and skilled; incidents were not analysed to inform improvements.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided safely. Risks were not always assessed, monitored and mitigated, there were insufficient staff to meet service user's needs and staff had not been checked to ensure they were competent and skilled; incidents were not analysed to inform improvements.

The enforcement action we took:

We took action to restrict admissions of new service users into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to assess, monitor and improve services, and assess, monitor and mitigate risks to service users had not been operated effectively. Records were not accurate and secure. the views of people, staff and relatives had not been taken into account to develop and improve the service.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to assess, monitor and improve services, and assess, monitor and mitigate risks to service users had not been operated effectively. Records were not accurate and secure. the views of people, staff and relatives had not been taken into account to develop and improve the service.

The enforcement action we took:

We took action to restrict admissions of new service users into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had the skills, knowledge, experience, training and support for them to fulfil their job roles competently.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had the skills, knowledge, experience, training and support for them to fulfil their job roles competently.

The enforcement action we took:

We took action to restrict admissions of new service users into the service.