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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 14 and 15 September 2017. The first day of the inspection was unannounced, however the second day of the inspection was announced and the registered manager, staff and people knew to expect us.

Rotherlea is a residential service providing accommodation for up to 70 older people, some of whom are living with dementia and who may require support with their personal care needs. On the day of the inspection there were 56 people living at the home.

Rotherlea is situated in Petworth, West Sussex and is one of a group of services owned by a National provider, Shaw Healthcare Limited. It is a purpose built building with accommodation provided over two floors which are divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. There are also communal gardens. The home also contains a day service facility where people can attend if they wish, however this did not form part of our inspection.

The home had a registered manager. A registered manager is a '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 home is run. The management team consisted of the registered manager, one unit manager and team leaders.

We previously carried out an unannounced comprehensive inspection on 26 and 27 July 2016. Breaches of legal requirements were found in relation to safe care and treatment, the need for consent, sufficiency, support and training of staff and governance. The home was rated as 'Requires Improvement'.

At this inspection it was evident that improvements had been made. Staff received training and appropriate support and guidance within their roles and quality monitoring systems, to enable the management team to have an oversight of the service that was provided, had improved. Risk assessments had been completed that identified the hazards and measures had been put in place to monitor and mitigate risk. As a result the registered manager was no longer in breach of these associated regulations. Although improved and therefore not in breach, an area in need of improvement related to the implementation of guidance in relation to peoples' healthcare needs. There was a new concern with regards to the lack of records to provide guidance to staff in relation to peoples' specific healthcare needs and to document staff's actions. There were continued breaches in relation to MCA and DoLS. Staff lacked understanding and the registered manager had not always ensured that peoples' capacity was assessed in relation to specific decisions. In addition, applications had not always been made to the local authority to ensure that people were not being deprived of their liberty unlawfully.

People were protected from harm and abuse as they were cared for by staff that knew how to recognise the signs of abuse and what to do if there were ever any concerns. Risks to people were assessed, monitored and mitigated and peoples' freedom was supported and respected according to their needs. Staff were

adequately supported within their roles and had access to training to enable them to deliver safe care to people. People told us that they were happy with the food and drink that was provided. Comments included, "Food good, given too much" and "Food much better, better selection than other home".

Staff were aware of peoples' needs and could recognise when people were unwell. People had access to external healthcare professionals to support them to maintain good health. Staff were kind and caring and people and relatives told us that they were happy with the support they received from staff and they were treated with dignity and respect. One person told us, "Staff ask in a nice way, all very good". Another person told us, "Staff very good, no complaints". A comment within a recent relatives' survey echoed these views, it stated, "I cannot fault the care given to my relative. The staff are caring and always meet their needs. I feel that we are supported as a family by everyone from the cleaners to management. I cannot fault my relatives, or my care, in any way'.

People were actively involved in decisions that affected their care. Regular residents' and relatives' meetings took place and quality assurance surveys sent, to enable people to share their views. Peoples' and relatives' views were respected and acted upon and changes made as a result. The registered manager welcomed feedback and people were made aware of their right to complain.

Peoples' care was personalised to their needs and staff took time to speak to people and listen to their views. Warm interactions were observed and people had access to meaningful interactions with each other, their relatives and staff. People were able to stay at the home until the end of their lives and were involved in decisions that affected their care at this time. Observations showed that people's wishes were respected at the end of their lives.

There was effective, on-going quality monitoring to ensure that the service was meeting peoples' needs. The culture of the home had improved. People, relatives, staff, the management team and external professionals all commented on how the much the atmosphere had improved. One member of the management team told us, "Rotherlea has drastically improved. It is now a nice friendly, happy place. The residents are happy and for me that is the most important thing".

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager 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 home was safe.

Risk were identified and monitored and there were assessments in place to ensure peoples' safety. However, guidance was not always implemented to ensure peoples' health and well-being.

People had access to medicines when they required them. There were safe systems in place to store and dispose of medicines.

There were sufficient numbers of skilled and experienced staff to ensure people living at the home were safe and cared for. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. However, there were inconsistent approaches to assessing peoples' capacity and to ensuring that people were not deprived of their liberty unlawfully.

People had access to health care services to maintain their health and well-being.

People were happy with the food provided and were able to choose what they had to eat and drink. People had a positive dining experience. People were cared for by staff that had received training and had the skills to meet their needs.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This included people at the end of their lives as people were able to plan for their end of life care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

There was a lack of detail in documentation to inform staff and demonstrate their practice. Care was personalised and tailored to peoples' individual needs and preferences.

People had access to a range of activities and meaningful stimulation.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Records to document the care that people received were not always completed. It was unclear if people had not received appropriate care or if staff had failed to record their actions.

Good quality assurance processes ensured the delivery of care and drove improvement. People, relatives, staff and healthcare professionals were positive about the management and culture of the home. The registered manager maintained links with other external organisations to share good practice and maintain their knowledge and skills.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

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 home, and to provide a rating for the home under the Care Act 2014.

The first day of inspection took place on 14 September 2017 and was unannounced. The inspection team consisted of three inspectors. The second day of inspection took place on 15 September 2017 and was announced. The inspection team consisted of two inspectors. The home was last inspected on 26 and 27 July 2016, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home received an overall rating of 'Requires Improvement'. Subsequent to the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches that were found. At this inspection we checked to ensure that these actions had been completed.

Prior to this inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to this inspection included previous inspection reports, feedback that we had received about the home and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eight people, five relatives, nine members of staff, the registered manager, the area manager and a visiting professional from the local authority. Prior to the inspection we had also communicated with a professional from the local authority to gain their feedback. Subsequent to the inspection we contacted healthcare professionals who often visited the home. Some people living at the home had limited or no verbal communication and were unable to speak to us. Therefore 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 reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for nine people, medicine administration records (MAR), eight staff records, quality assurance audits, incident reports and records

relating to the management of the home. We observed care and support in the communal lounges and in peoples' own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 26 and 27 July 2016 the provider was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns that risks, although identified, had not always been monitored or mitigated, medication management systems were not effective and there was insufficient staffing which had impacted on the cleanliness of the home and staffs' abilities to meet peoples' needs in a timely manner. Subsequent to the inspection the provider wrote to us to inform us of the actions they would take to meet the regulations. At this inspection it was evident that improvements had been made and the provider was no longer in breach of the regulations.

Peoples' risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not unintentionally losing weight. Records for some people showed that they had been assessed as being at a higher risk of malnutrition and the registered manager had ensured that changes were made to the frequency in which the person was weighed so that they were monitored more closely. In addition, peoples' food and fluid intake had been recorded to monitor what people were eating. Records of these showed that staff were provided with sufficient guidance with regards to the optimum daily amount of fluids people could have so that they knew when to report issues of concern if people had not had sufficient fluids.

Referrals to external healthcare professionals had also been made for people who were at risk of malnutrition, these included referrals to the GP, dietician and SALT. However, advice provided by these professionals had not always been followed and implemented in practice. Records for one person showed that they had been assessed by a SALT who had advised that the person be given thickened fluids to assist them to swallow and to minimise the risk of choking. However, observations showed that the person had a jug of juice beside their bed, as well as a glass of juice and a cup of tea. Not all of these fluids contained thickener. When staff were asked about the thickening of fluids they provided mixed responses. Some staff were unsure how much thickener to add to the person's fluids whilst others were able to provide an accurate explanation. One member of staff was preparing a cup of tea for the person, when asked if the person had thickener in tea they told us that they only had thickener in their juice and not in their tea, but they were unsure why. This was brought to the attention of staff who immediately ensured that the person had access to fluids with the recommended thickener in. Care plan records for the person contained clear and detailed information, advising staff of the risks in relation to choking and the measures that staff should take to minimise these, such as adding a specified amount of thickener to the persons' drinks. Although there had been no adverse effects on the persons' health, there was a varied understanding of the guidance that had been provided within care plan records and by the external healthcare professional. When this was fed back to the registered manager they told us that they would remind staff of the importance of adhering to the guidelines provided in peoples' care plans. Staffs' understanding and awareness with regards to the records and practices that were in place to ensure peoples' health and well-being is an area of practice that needs to be further embedded in practice.

At the previous inspection there were significant and wide-spread concerns with regards to medicines management and this had sometimes affected peoples' access to them. A new electronic medicines management system had been introduced. There were anomalies in the stock levels and some people had gone without their medicines. Training on the use of the electronic system had not been provided to all staff that required it. Audits for medicines management had not been completed. Subsequent to the inspection, with updates provided on a regular basis, the provider had sent CQC audits of the medicines management. These demonstrated that measures to improve medicines management had been introduced, were effective and sustained over time.

At this inspection it was evident that medicines management had improved and the provider was no longer in breach of the regulation. There had been communication with external healthcare professionals to clarify the type of information they required to enable them to provide appropriate medicines for people. People were assisted to take their medicines by staff that had received the appropriate training and who had their competence regularly assessed. Staff accessed peoples' medicine administration records using a laptop computer and used this to record when they had observed people take their medicines. Staff told us that this assisted them to administer medicines safely as it informed them of what medicines were due as well as the stock levels of medicines, which were found to be correct and in line with the stocks that were available for people. The registered manager used the system to monitor and audit the administration of medicines to identify if any errors had occurred. Observations showed peoples' consent was gained and they were supported to take their medicine in their preferred way. People, who were able, told us that they received their medicines safely and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People, who were able, were encouraged to continue to self-administer medicines and relevant policies and risk assessments were in place to ensure their safety.

At the previous inspection there were concerns with regards to sufficient numbers of staff. There was a high use of temporary staff, who had little understanding of peoples' needs and preferences and staff felt under pressure due to the levels of staffing. At this inspection people, relatives and staff told us that there were sufficient numbers of staff to meet peoples' needs and our observations confirmed this. One person told us, "Yes, there are enough staff". When asked about the staffing levels, a relative told us, "It has got better. If my relative needs someone there is never not anyone around, they know my relative and know what they like". Another relative told us, "There are always staff in the lounge". There were two members of staff allocated to each unit. All but one unit was designed in such a way that, although self-contained, could be opened up to create an open-planned space so that dining and living spaces could become shared, communal spaces. Two staff were allocated to each unit, with an additional member of staff available between the two adjoining units. This meant that if people required support from two members of staff, there was always a member of staff available within the communal space to support people. In addition, each floor had a team leader.

The home is based in Petworth, West Sussex; the provider had struggled, despite various initiatives, to recruit to the home due to its rural location. Measures such as recruiting from overseas, providing staff transport and looking at possible accommodation for staff had been implemented. The provider was continuing to recruit, however in the interim period had ensured that there were sufficient staff to meet peoples' needs through the use of temporary staff. Efforts had been made to ensure continuity of staff as the registered manager only used two agencies which provided staff that had worked at the home numerous times before. This was further demonstrated through a comment made by one person, who was unable to differentiate between temporary and permanent staff as the temporary staff had worked at the home so often. Staff, both permanent and temporary, knew people well and supported them according to their needs and preferences.

In addition to the use of regular temporary staff, the provider had recruited a unit manager who had, along with the registered manager, worked with staff to improve their confidence and abilities. The unit manager had a visible presence throughout the home, offering support to staff and people alike. Measures to improve communication amongst the staff team had been taken, regular meetings with staff, to inform them of peoples' needs and of the running of the home, took place. This meant that staff were kept informed about the home and were more aware of changes in peoples' needs. This helped create a more positive culture where staff were kept informed, felt supported and involved in the running of the home. Staffing levels had improved and people felt that staff responded to their needs in a timely manner. There were decreased occupancy levels, however, the registered manager had chosen to keep staffing at the same level as if the home was at full occupancy. When asked how sufficient staffing levels would be sustained, should occupancy levels increase, they explained that they had already started to become more realistic when assessing peoples' needs prior to them moving into the home, that when doing this they looked at this alongside the needs of existing people who lived at the home, ensure that staffing levels could meet peoples' assessed level of need.

At the previous inspection, due to the lack of staffing, there were concerns with regards to the cleanliness of the home as staff responsible for this were sometimes called to attend to peoples' needs. At this inspection improvements had been made, the home was clean and people and relatives were happy with the cleanliness of the home. Subsequent to the previous inspection measures to improve cleanliness had been implemented. In addition to the recruitment of additional staff and the use of temporary staff, the registered manager had outsourced the laundering of sheets and towels, this had enabled staff that were responsible for the laundry, to spend more time cleaning the home.

At the previous inspection it was noted that risks in relation to peoples' skin integrity, fluid intake and falls management had been identified but had not always been monitored or mitigated sufficiently to ensure peoples' safety. At this inspection improvements had been made and the provider was no longer in breach of the regulation. Peoples' needs had been assessed and risk assessments were devised and implemented to ensure their safety. Action in response to risk had been undertaken, for example, records for two people, who had been assessed as being at higher risk of falls, showed that referrals to external falls prevention teams had taken place and measures to minimise the risk of falls occurring had been implemented. Accidents and incidents that had occurred were recorded and analysed to identify the cause of the accident and determine if any further action was needed to minimise the risk of it occurring again. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and peoples' ability to evacuate the building in the event of an emergency had been considered, as each person had an individual personal emergency evacuation plan. A business continuity plan informed staff of what action needed to be taken in the event of an emergency.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing, identity and security checks had been completed, and their employment history obtained. In addition to this, their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Where people received support from temporary staff, the registered manager had requested a profile from the agency which included information on their DBS and a record of their training.

People, their relatives and healthcare professionals told us that the home was a safe place to live. One person told us, "As far as I know it's a safe place, security is good". Observations showed people were

relaxed in the company of staff. Staff had a good understanding of safeguarding adults. They had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. Incident records and body map charts recorded injuries that people had sustained so that these could be monitored to ensure peoples' safety. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to people and staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 26 and 27 July 2016 the provider was in breach of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were inconsistencies in staffs' understanding about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Decisions had sometimes been made on peoples' behalves, without their capacity being assessed. Some people, who lacked capacity, had not always had DoLS applications made to ensure that any restrictive practices were not unlawful. In addition, there was a lack of timely training for staff as well as training that was specific to peoples' individual health conditions and a lack of formal supervision. Subsequent to the inspection the provider wrote to use to inform us of what they would do to meet the regulations. At this inspection, although improvements had been made and the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014, there were continued concerns with regards to the assessment of peoples' capacity and DoLS applications to ensure that restrictive practices that were used were lawful.

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. At the previous inspection it was identified that, although peoples' capacity had sometimes been assessed, this had not always been decision specific and as a result peoples' capacity had not been assessed appropriately and in line with the MCA. At this inspection it was unclear what improvements had been made. People were asked their consent for day-to-day decisions that affected their care; however, records showed that there were two different mental capacity forms. One form assessed peoples' overarching capacity to make decisions. However, this was not decision specific and was therefore not in line with MCA. Another record showed that peoples' capacity had been assessed in relation to specific decisions. However the use of this second form was not consistent and some peoples' capacity had not been assessed in relation to decisions that affected their care. There were inconsistent approaches with regards to the assessment of capacity and consent to care. For example, one person had their overarching capacity assessed as being able to make decisions. However, the consent form for the use of bed rails was signed by the person's relative and a member of staff. The registered manager had taken measures to improve staffs' understanding. Records of a staff meeting showed that staff had been reminded of the main principles of the MCA.

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 DoLS. At this inspection we checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being recorded and met. At the previous inspection it was identified that there was a lack of understanding about DoLS as well as untimely action to make DoLS applications, and as a result people were being deprived of their liberty unlawfully. At this inspection, although some measures had taken place to increase staffs' understanding, there were continued inconsistencies with regards to staffs' understanding of DoLS

and which people were subject to them. Some staff were able to name which people had a DoLS and if there were any conditions attached to them, whereas others were unsure. This raised concerns as to what staff would do if a person wanted to leave the home unaccompanied.

The home is spread over two floors. The lower floor is home to people who are living with dementia. Some people had restrictive practices in place, such as a locked door to the floor, to ensure peoples' safety. The registered manager had sought advice from the local authority with regards to the application of DoLS. The registered manager told us that they had been advised that if a person was content to stay at the home and was not asking to go out, that a DoLS application did not need to be applied for. However, when staff were asked what they would do if a person who lacked capacity asked to go out of the home unaccompanied, they explained that they would ask the person to return to the home. This meant that the person was under continuous supervision and without a DoLS authorisation being in place; they were being deprived of their liberty unlawfully. The provider had not ensured that care and treatment was provided with the consent of the relevant people. Therefore this was in continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection there were concerns with regards to the training that was available to staff to enable them to effectively meet peoples' needs. Staff had not always received training in a timely way to enable them to operate the computer systems that were in place to manage medicines and therefore were not always able to safely administer peoples' medicines. There were also concerns with regards to staffs' access to training that was specific to peoples' healthcare needs. At this inspection, it was clear that improvements had been made as staff had received training. Training to meet peoples' specific needs was available such as dementia care, with different lengths of course dependent on staffs' roles. Staff had also completed training which the registered manager considered essential to their roles. There was mixed feedback with regards to the skills and experiences of staff. People and relatives told us that they thought staff had appropriate skills to meet peoples' needs. However, feedback received from healthcare professionals subsequent to the inspection, indicated that they felt that there were lower numbers of suitably skilled staff to meet peoples' needs when their health deteriorated. They explained that they felt that, as a result, due to experienced staff being required to support people with complex health conditions or at the end of their lives, this increased the workload for other staff, as there were not enough staff, with appropriate skills, to meet other peoples' increasing health needs. The provider and registered manager were working to improve this, by continuing to try and recruit experienced and skilled staff and by ensuring that there was a suitable skills mix of staff when allocating work to meet peoples' needs.

There was a commitment to learning and development from the outset of staffs' employment. New staff were supported to undertake an induction which consisted of familiarising themselves with the provider's policies and procedures, orientation of the home, as well as an awareness of the expectations of their role and the completion of the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers.

At the previous inspection, staff told us that they were not always supported effectively and there was a lack of access to formal support and supervision. At this inspection, improvements had been made. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss their needs and any concerns they had. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive, however, explained that they could also approach the registered manager at any time if they had any questions or concerns. The provider had additional plans in place to ensure that staff were appropriately supported and had plans to

invite a well-being team into the home to help with staff morale, stress levels and well-being.

Peoples' communication needs were assessed and met. People had access to opticians and audiologists and were provided with equipment to aid their communication. Records for one person, who was sight impaired contained information and guidance for staff with regards to how to support the person effectively. Effective communication continued amongst the staff team. Regular handover meetings and team meetings, as well as care plans, ensured that staff were provided with up-to-date information to enable them to carry out their roles.

Peoples' health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, dieticians, speech and language therapists (SALT) and district nurses. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support and people confirmed this. Records showed that staff monitored peoples' healthcare needs and made timely referrals to GPs if peoples' health had deteriorated.

Peoples' skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had pressure wounds, district nurses visited regularly and ensured that wound assessment charts had been completed providing details of the wound and the treatment plan recommended, effective monitoring also took place to monitor for improvement or deterioration. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses.

People had a positive dining experience and told us that they enjoyed the food and had a choice of menu each day. People ate their meals in the dining room, or in their own rooms, dependent on their preferences and care needs. The dining rooms created a pleasant environment for people, tables were laid with tablecloths, placemats and condiments and people could choose what they had to eat and drink. People told us that they got sufficient quantities of food and drink and that they enjoyed the food that was provided. Comments from people included, "Food good", "Food is okay, fish pie and shepherd's pie are my favourites" and "Food is much better, better selection than at the other home". Observations showed that people were provided with choice and were able to change their minds if they did not want the choice they had originally opted for. Good practice was demonstrated when staff were offering choice to people who were living with dementia. Meals were served onto plates and these 'show plates' were shown to people to assist them to choose the food. Mealtimes were a sociable experiences. Observations showed some staff sitting alongside people to have their own lunch and engaging in conversations with one another over their meals. After people had eaten they were encouraged to sit with staff to have a 'tea and chat' to make the experiences more relaxed and enjoyable.

Good

Is the service caring?

Our findings

At the previous inspection on 26 and 27 July 2016, an area in need of improvement related to the variation in the caring nature of staff and in their person-centred approaches. At this inspection it was clear to see improvements had been made. Staff were happy in their work, there had been a commitment to ensuring that staff, although temporary, were consistent, to ensure that positive relationships, between people and staff developed. Staff knew people well and supported people according to their individual needs and preferences. Feedback from people and relatives was positive and they told us that they were happy with the staff and that they demonstrated kindness and compassion. Our observations confirmed this.

People and relatives were complimentary about the caring nature of staff. One person told us, "Nice staff". Another person told us, "Staff are very good, no complaints". A relative told us, "The staff that I know are all very good, all friendly and polite. I'd be heartbroken if my relative had to leave here". Comments within a recent residents' survey further confirmed peoples' positive opinions of staff. They included, 'Staff are helpful and understanding', 'Good carers' and 'Looked after well'. These comments were echoed in a recent relatives' survey. Comments included, 'Rotherlea is a caring home, in which my relative is happy and settled', 'Amazing home to be in, staff are fantastic, caring and always available. Family atmosphere' and 'I cannot fault the care given to my relative. The staff are caring and always meet their needs. I feel that we are supported as a family by everyone from the cleaners to management. I cannot fault my relatives, or my care, in any way'.

There was a friendly, welcoming and relaxed atmosphere. Observations of staffs' interactions showed them to be kind and caring, they took time to explain their actions, offer reassurance and ensure people were comfortable and content. When people showed signs of apparent anxiety and distress, staff were patient and calm and took time to speak with them to offer reassurance and support. Observations showed that, on the whole, this minimised peoples' distress and people were seen smiling and engaging in conversations when their distress or incidents had been diffused. People were treated with respect by staff who took time to explain their actions and involve people in the care that was being provided.

People could independently choose how they spent their time, some spending time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. Peoples' independence was promoted and encouraged. Observations showed some people accessing the community with their relatives or making cups of coffee for themselves in the communal kitchen area. Other people, who were less independent, were observed walking around the home using their mobility aids and choosing where and how they spent their time. Observations showed staff encouraging independence where possible. For example, during lunchtime staff noticed that one person was struggling to pick up food on their fork. The member of staff discreetly approached the person and asked if they needed assistance, they then placed some food onto the person's fork and handed this back to the person so that they could eat unassisted. When people were asked within a recent survey what they liked about the home, one person had commented, 'Independence and there is always help when I need it'.

Peoples' privacy was respected. Staff showed a good understanding of the importance of privacy and

dignity and people confirmed that these were promoted and maintained. Observations showed staff knocking on peoples' doors before entering, explaining their actions, demonstrating respect for peoples' dignity and taking time to acknowledge peoples' feelings. When people required assistance with their personal care needs, staff attended to these in a sensitive and discreet way. Meetings to discuss peoples' changing needs took place in private offices to ensure others didn't hear the content of the conversations. Information held about people was kept confidential as records were stored in locked offices to ensure confidentiality was maintained.

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences.

People and relatives told us that people were involved in decisions that affected their care and our observations confirmed this. Records showed that people and their relatives had been asked preferences and wishes when they first moved into the home and that care plans had been reviewed in response to peoples' feedback or changes in their needs. Regular surveys were sent to people and their relatives to gain their feedback. Regular residents' and relatives' meetings took place enabling people to have an input into the running of the home and their care. People and relatives told us that they felt involved in the delivery of care. Observations showed relatives talking with staff about the care their relative had received. The registered manager had recognised that people might need additional support to be involved in their care; they had involved peoples' relatives or social workers, when appropriate and if required people could have access to an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the home and were supported until the end of their lives. Observations showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Records for one person, who was receiving end of life care, showed that they had discussed their wishes prior to their health deteriorating. They had stated that they wanted to be cared for at the home and they would like to listen to a certain channel on the radio. Observations of the person showed that this had been respected. The person was able to listen to their chosen radio station and received regular support from staff to ensure their comfort. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 26 & 27 July 2016 the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with the sufficiency of staff and the impact this had on staffs' ability to meet peoples' social and emotional needs as well as ensuring people had access to stimulation and meaningful occupation. At this inspection it was evident that improvements had been made. Staffing levels had improved and occupancy levels had decreased, this meant that staff were able to spend time with people, enjoying conversations or partaking in activities. However, we found an area of practice, related to the recording of information about peoples' care needs and the actions of staff, that required improvement.

Although care plans contained information about each person, there were sometimes inconsistent approaches to planning peoples' care. For example, one person who was living with diabetes had a care plan informing staff of the person's needs and another person, who was also living with diabetes, did not. Care plans that were in place sometimes lacked detail and did not always provide staff with sufficient guidance to enable them to understand and meet peoples' individual healthcare needs. For example, care plans for people living with diabetes did not inform staff of what to do if the person's blood sugar levels became too high or too low, neither did it inform staff of the importance of regular eye or foot care to maintain peoples' health. One person was living with dementia and sometimes displayed behaviours that challenged others. However, staff had not been provided with guidance to inform them of triggers to look for that might escalate the person's anxiety and behaviour, neither were staff provided with guidance as to how to support the person to manage their behaviour when they became anxious and distressed. Observations showed the person frequently became anxious and distressed. Staff demonstrated a calm and patient demeanour, however, varied in their approach as to how to support the person. As a result the person often showed signs of apparent confusion and disorientation. Care records did inform staff that the person enjoyed one to one time with staff and when staff offered this support it was apparent that this was sometimes that the person liked as they were calm and were smiling and laughing with staff. However, other staff appeared not to know how to support the person appropriately and in accordance with their wishes. Consistent and detailed care plans and documentation are of particular importance due to the high use of temporary staff that are used. Due to inconsistent records and lack of detail in records, staff were not always provided with consistent guidance to inform their practice to ensure that people were supported according to their needs and in a consistent manner. When this was fed back to the management team they explained that new, electronic care plans were going to be introduced and that this would provide them with the opportunity to ensure that care plans were more detailed, informative and specific to peoples' needs.

Care plans had been reviewed regularly. The registered manager operated a system whereby the care plans of two people, whose room numbers corresponded with the days of the month, would be reviewed each day. These recognised changes in peoples' needs and staff's practice had changed as a result. For example, one person had experienced a number of falls from their bed. In response, the person's care had been reviewed and the person had agreed that bed rails would be used during the night to reduce the risk of this reoccurring. Staff had recognised this change and the person's care plan had been updated to ensure that all staff were made aware of the change and were able to support the person effectively.

There was mixed feedback from people about the activities and stimulation that was provided. Comments within a recent quality assurance survey sent to people and relatives, contained a comment from a person, which stated, 'I enjoy going out'. Another comment stated, 'Not much to do'. This was echoed within a conversation between two people, one of whom said "I'm bored", the other person replied, "I think we all are". However one person told us about a recent visit to a nearby village and their love of knitting. The provider employed a dedicated activities coordinator to support people to take part in different activities as well as organising external entertainers. Care staff were also involved in providing stimulation and engagement and observations showed staff took time to sit and talk to people. Activities that had been offered to people, who were able to take part, included pub lunches, arts and crafts, exercises, knitting, bingo, external entertainers and quizzes. Observations showed people had enjoyed taking part in a 'Make a Wish' activity. A 'Wishing Tree' had been made and people and their relatives had been encouraged to write down peoples' wishes and pin these to the tree. Each month three wishes would be picked from the tree and plans made to support people to fulfil their wish. People appeared to enjoy this activity and this ignited conversations between people.

Peoples' preferences, hobbies and interests had been documented in their care plans, as well as their life history, this provided staff with an insight into peoples' lives before they moved into the home and observation showed staff talking with people about their families. People and their relatives, were able to make their suggestions known within regular residents' and relatives' meetings. Records showed and people and relatives confirmed that their suggestions were listened to and acted upon. People, who chose to spend time in their rooms, or those who were unable to partake in the organised activities, enjoyed listening to music, watching their televisions or reading their newspapers. A second activity coordinator had been recruited to provide more opportunities and stimulation for people. However, due to the lack of documentation, it could not be evidenced how much stimulation and meaningful occupation was available to these people. For example, care plan records that documented meaningful occupations were often blank and those that were completed had gaps in recording. This made it difficult to determine if the people had not been offered activities or if staff had failed to complete the records to document peoples' involvement. There was a lack of accurate, complete and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make choices in their everyday life. Observations showed staff respecting peoples' wishes in regards to what time they wanted to get up, what clothes they wanted to wear, what activities they wanted to do, what they had to eat and drink and what they needed support with. Peoples' needs and preferences had been recorded in care plans that were centred on peoples' individual needs.

People and relatives told us that they were involved in decisions that affected peoples' care, could approach staff if they had any concerns or questions at any time and were encouraged to make their thoughts and feelings known. There was a complaints policy in place. Complaints that had been received had been dealt with according to the providers' policy and procedure. The registered manager encouraged feedback from people, relatives and staff, there were regular questionnaires sent to obtain feedback and leaflets were displayed advising people and relatives of a website where they could leave feedback about the home and the care provided. People and most relatives told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager. One person told us, "I haven't had trouble but if I had a complaint I'd go to the team leader".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 26 & 27 July 2016 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of on-going quality monitoring of the service to ensure that it was meeting peoples' needs. This meant that issues with regards to the management of medicines, the cleanliness of the home and the auditing of the systems that were in place to ensure that they were effective had not taken place. Subsequent to the inspection the registered manager wrote to us to inform us of what they would do to meet the regulations. At this inspection, it was evident that improvements had been made. People, relatives, staff and healthcare professionals were complimentary about the leadership of the home; however, despite this we found an area of practice that continued to require improvement.

Although the registered manager had met the requirements of the previous breach in relation to quality assurance processes, we found that they were in continued breach of a new section of this regulation. This related to the management of records. Records, in relation to peoples' care and treatment, were not always consistently maintained. For example, some people, due to being at increased risk of developing infections, had their fluid levels monitored. However, records showed that these had not been completed consistently or in their entirety. Other records, to monitor the frequency in which a person required repositioning to minimise the risk of developing pressure wounds, were not completed in their entirety, nor were charts to document the application of creams to support peoples' skin integrity. Therefore these incomplete records did not provide staff with guidance as to the care a person had received and made it difficult to determine if people had received appropriate care or if staff had failed to complete the required records. The registered manager had not ensured that there were accurate, complete and contemporaneous records for each person and was therefore in continued breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection there were concerns with regards to the inconsistency of audits and quality checks to ensure that systems were effective. Audits conducted by both the registered manager and the provider, had not always been completed, and therefore there was a lack of oversight of the systems and processes within the home to ensure that they were effective. At this inspection improvements had been made. There were mechanisms in place to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving. This ensured that people were receiving the quality of service they had a right to expect. Records showed that action had been taken in response to peoples' feedback. For example, the registered manager had monitored peoples' responses from the recent quality assurance surveys. They had commented, within the audit, 'Main comments seem to be around the food and activities. I will hold a meeting with the kitchen and activity staff to see how improvements can be made. I'll ask them to speak to the residents to gain their insight into ideas for improvements'. Further action had been taken in response to peoples' feedback. Records of a residents' and relatives' meeting showed that the provision of activities had been discussed. Suggestions had been made with regards to introducing some light exercises to the regular activities that were offered. A timetable for the activities provided to people on a weekly basis showed that this had been introduced in response to peoples' feedback.

A quality management system was in place that ensured that regular audits of the service, which included quality of life audits, were conducted by the registered manager and other external senior managers and were monitored by the providers' quality team. Action plans as a result of the audits were implemented and monitored to ensure that any improvements that needed to be made were completed appropriately and in a timely manner. The local authority also undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting peoples' needs. Audits and action plans from the previous inspection to the current day, showed a steady improvement in the service people received and an action plan from recent audit contained much less actions than previous ones. The most recent audit had awarded a score of 90% compliance.

The management team consisted of a registered manager, a unit manager, team leaders and an area manager who regularly visited the home. There was a welcoming, relaxed and friendly atmosphere and people and relatives told us that people were content living at the home. The management team acknowledged the shortfalls at the previous inspection and explained that there had been a breakdown in communication between management and staff as well as with external organisations. They explained that it had taken time to build and improve the trust and confidence, but that improvements had been made and this in turn had improved the service people received. A unit manager had been recruited and they had worked hard to engage the staff team and build their knowledge and confidence. The registered manager told us, "Morale has lifted, the staff team are a lot happier, they feel confident again, we've built up good relationships with external services, such as the community nurses and admission avoidance matrons, we're still not perfect, but we're in a much better place, things are better and I feel confident". This was echoed in a comment made by another member of the management team, who told us, "Rotherlea has drastically improved. It is now a nice friendly, happy place. The residents are happy and for me that is the most important thing".

There were links with external organisations such as the local authority, healthcare professionals and support services to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. People, relatives, staff, the management team and external professionals all recognised that the culture at Rotherlea, and the willingness of management and staff to engage with other, external organisations, had improved. An external professional told us, 'In January it was noted that there had been some difficulties and poor relationships with Health and Social Care Professionals within the community. Since then Shaw Healthcare have continued to work with West Sussex County Council to improve working relationships and in the last 3-4 months we have seen a marked improvement at Rotherlea which has been commented on by Social Care and the Admission Avoidance Matrons'. This willingness to engage and accept support from external sources had helped to ensure that peoples' experiences improved and that the staff team were following best practice guidance. The registered manager attended senior management meetings and was supported in their role through these meetings, as well as through regular supervision and support from their line manager who frequently visited the home.

The registered manager demonstrated their awareness of the implementation of the Duty of Candour CQC regulation and records showed that they had informed peoples' relatives if peoples' health needs or condition had changed. This was confirmed by relatives who told us that they were involved in their loved ones care and kept up-to-date when changes occurred. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not maintained securely an accurate, complete contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

The enforcement action we took:

We have issued a Warning Notice for this breach of Regulation. The provider is required to be compliant with the Regulation within a set timescale and we will re-inspect the home to ensure that this has been adhered to.