City Health Care Limited

Rossmore Nursing Home

Inspection report

62-68 Sunny Bank
Hull
East Yorkshire
HU3 1LQ

Tel: 01482343504

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was completed on 14 and 15 March 2017 and was unannounced. City Health Care Limited has been the new registered providers of Rossmore Nursing Home since September 2016. This is their first inspection since registration and was brought forward from the planned date due to a notification of an incident that raised concerns.

Rossmore Nursing Home is registered to provide personal and nursing care for up to 56 people. The service is accommodated in a series of converted, large, terraced houses in a residential area of Hull, close to amenities and public transport; there is on street parking available. The service has 17 placements for people who have had a stroke and who require therapy input to assist their rehabilitation; an adjoining house has been purchased next door to extend the stroke unit. The day therapy activity is currently provided by Humber NHS Foundation Trust in a separate building in the grounds of Rossmore Nursing Home. There are also eight step-down placements for people who require an interim service following discharge from hospital until a package of care can be arranged for them in the community. The remaining 31 placements are for people who require on-going residential and nursing care. There is a large sitting room, a small seated area and a dining room on the ground floor. There is a mixture of single and shared occupancy bedrooms on the ground and first floors; the upper floors are accessed by a passenger lift, a stair lift and stairs. There are bathroom and shower facilities on both floors.

The service had a registered manager in post as required by a condition of their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Due to concerns found during the inspection, 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.

Following the inspection, we met with the registered provider and have received an interim action plan. We also requested and have received weekly updates to assure us actions have been taken to address the concerns. We found multiple concerns and are considering our regulatory response. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take at the back of the full version of the report.

We found concerns with how the service was governed. The support system for the registered manager had shortfalls which meant they were managing the four distinct areas of the service as one, without effective clinical guidance and support. The registered provider told us directors, and a senior nurse employed within the company, were available to support the registered manager. The CQC had not always received notifications of incidents which affected the welfare of people who used the service. Communication and documentation was poor in some areas which meant the registered manager had not been informed of important incidents to enable them to take action. There were discrepancies and inaccuracies regarding the records of some people who used the service which made it difficult to check if the correct care and treatment had been delivered. There were different systems of recording in the service which added to the confusion. For example, therapists in the stroke unit recorded their care plans and treatment records on a computerised system but the nursing and care staff did not have access yet so were unable to see the information.

The quality monitoring system was very new and had not been fully developed; the registered provider had concentrated on external structural work, had completed a full infection control audit and a full medicines audit. However, there was a range of internal issues that had not been addressed effectively. These included cleanliness, documentation, medicines management, nurse staffing arrangements, inconsistent application of mental capacity legislation, safeguarding reporting, safe care and treatment, risk management, assessments and care planning. We found accidents had been logged, which highlighted specific issues but lacked analysis to ensure lessons were learned to prevent reoccurrence.

We found the arrangements for nurse cover during the day and night had led to shortfalls on occasions and an over-reliance on agency nurses on others. This meant there had been an inconsistency of care and treatment, poor communication in sections of the service and people's care needs being overlooked.

Some people had not received their medicines as prescribed due to stock control issues and errors in administration. There were occasions when people's health care needs were not met in a timely way and there were concerns about how the staff team worked with other health professionals when people's care and treatment was shared between them.

There was a lack of robust risk assessment and management; staff had not always followed policies and procedures, guidance from health professionals and outcomes from risk assessments. Areas of the environment were cluttered with equipment and rooms such as sluices were constantly accessible to people which made them unsafe. These issues had placed people who used the service at risk of harm and injury.

Not all staff had received safeguarding training and there had been occasions when incidents had not been reported properly to the local safeguarding team so they could review how they were being managed.

Not everyone who used the service had a care plan and there were significant gaps in care planning for other people. Also care plans were not always updated when people's needs changed. This meant staff did not have up to date information about people's individual needs and important person-centred care could be missed.

We found there was an inconsistent application of mental capacity legislation. Some people had assessments to determine their capacity to consent to specific restrictions such as bed rails but others did not. Documentation that showed best interest decision-making had not been completed appropriately. There was also one person whom we felt should have been assessed to see if they met the criteria for a deprivation of liberty safeguard; they were agitated, confused and wanting to leave the service.

There were concerns with the management of infection prevention and control as some areas of the service and equipment required cleaning. Refurbishment was underway; at present this was the exterior of the building but there were also plans to upgrade the interior in the near future.

Staff had access to training and those spoken with confirmed this had improved since the new registered provider took over. There were gaps in training but these had been identified and plans put in place to address them. We made a recommendation that the registered provider follows through with the training plan and we will assess this at the next inspection. New staff supervision support meetings had just started and the registered manager had plans to ensure senior staff were suitably trained to enable them to carry out formal supervision. Staff told us they felt supported by the registered manager.

People told us the staff approach was kind and caring and they felt able to raise issues with them. We observed positive interactions between staff and people who used the service although improvements could be made in some areas to ensure privacy and dignity was enhanced.

We found people's nutritional needs were met. There was a varied menu which provided people with choices and alternatives. People told us they liked the meals provided to them.

There was a range of activities and therapies for people to participate in; some people were supported to attend a local social club and enjoyed outings when possible.

Staff were recruited safely and employment checks were carried out before new people started work in the service.

There was a policy and procedure to guide staff in how to manage complaints and a record was held of investigations and outcomes. The new registered provider's complaint policy and procedure was included in a service user's directory but not displayed in the service. The registered manager told us they would rectify this.

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.

Risk had not been managed effectively, which had placed people who used the service at risk of harm and injury.

There were policies and procedures to guide staff in how to safeguard people from abuse and harm; however, these had not always been followed.

Some people had not received their medicines as prescribed.

There were several instances when there were insufficient qualified nurses on duty to be able to manage specific aspects of the nursing care people required and an over reliance on agency nurses had impacted on consistency of care.

Some areas of the service, and some equipment used, required cleaning to ensure it met acceptable standards of hygiene.

Is the service effective?

Inadequate

The service was not effective.

Some people's health care needs had not been managed appropriately. This placed people at an increased risk of receiving inadequate care and treatment.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards, which meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions.

Staff had access to training, supervision and support. The supervision process had just started and there were gaps in training but these had been identified and plans put in place to address them.

People who used the service told us they enjoyed the meals provided and were able to choose from a varied menu so their nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were observed as having a kind and caring approach and people spoken with confirmed this.

Staff treated people with respect. There were some adjustments that could be made to ensure people's privacy and dignity was maintained.

Staff maintained confidentiality and stored people's personal and medical information securely.

Is the service responsive?

Inadequate

The service was not responsive.

Some people who used the service did not have a plan of care to enable staff to deliver person-centred care. This meant important care preferences had been overlooked and staff responses to changes in people's needs had not been timely.

There was a lack of coordination and communication with other health professionals involved in people's treatment in the stroke rehabilitation service.

People had access to a range of activities and therapy sessions.

The registered provider had a complaints policy and procedure and people felt able to raise concerns knowing they would be addressed.

Is the service well-led?

Inadequate

The service was not well-led.

There were shortfalls in overall governance of the service and support and guidance for the registered manager. The quality monitoring system to help to identify shortfalls, to learn from incidents, to survey people's views and to develop action plans to address issues had not been developed.

There were shortfalls in recording which meant there was not accurate and up to date information about people's needs, which could place them at risk of not receiving appropriate care and treatment.

The Care Quality Commission had not always received

notifications of incidents which affected the safety and wellbeing of people who used the service. We have written to the registered provider about this.

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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 registered 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 14 and 15 March 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service. We also checked documentation which was completed when the Care Quality Commission registered the service in September 2016.

Prior to the inspection, we spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with five people who used the service and four people who were visiting their relatives. Seven other relatives completed a short questionnaire we gave them during the inspection. We spoke with two of the directors of the service, the registered manager, two nurses, four care workers (two of whom were seniors), the activity co-ordinator and the chef. On the stroke unit we spoke with four members of the Humber NHS Foundation Trust therapy team, the GP who attended the multi-disciplinary team meeting, an agency nurse and a care worker. Following the inspection, we held a meeting with the Chief Executive Officer of City Health Care Limited.

We looked at four care files for people resident in the service, five care files for people receiving stroke rehabilitation service and seven care files for people occupying step-down beds. We also looked at other

important documentation relating to people who used the service such as medication administration records (MARs) for 20 people and monitoring charts for food, fluid, weights, pressure relief and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We spoke with the registered manager about the recruitment system and how they ensured employment checks were carried out before staff started work in the service.

We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

We found concerns regarding how risk was managed within the service. There were some risk assessments completed for skin integrity, moving and handling, the use of bed rails, nutrition, leaving the service unattended and falls. However, these were not consistently completed for all the people who had identified needs in these areas. Some people who used the service had a risk of developing pressure damage but an assessment and care plan were not in place to guide staff. On one occasion, a person had developed pressure damage as the risk had not been managed appropriately. Some people had nutritional and hydration concerns on admission but a risk assessment was not always in place to identify them and guide staff in how to minimise them. The risk assessments for people leaving the service unattended did not provide all the control measures to guide staff in how to minimise risk. This was despite a serious incident which occurred when a person left the service and staff failed to follow the missing person policies and procedures.

Accident records indicated one person had sustained bruises on two occasions when staff used a specific piece of equipment. A risk assessment had not been completed following the first incident to guide staff on how to support the person to prevent a reoccurrence. Similarly, we found staff had not used a piece of equipment in the correct way, which although on that occasion did not cause the person harm, there was the potential to do so. There had been one occasion when staff used bed rails contrary to the outcome of an assessment which had deemed they were not to be used as the person would be at risk of climbing over them. It was advised the same person required a sensor mat to alert staff when they tried to get out of bed, but there was a delay in this being provided. We saw there were several old style bed rails in the stroke unit which could pose a risk to people who used the service. These had not been identified in any risk management plan.

Risks in the environment had not been managed appropriately to ensure people were safe. For example, areas of the service such as bedrooms and bathrooms were cluttered with equipment, some of which were no longer in use and posed a trip hazard. A fire extinguisher in the lounge was blocked by an easy chair and a fire extinguisher on one of the landings was blocked by a medicines trolley. The two sluice rooms were found unlocked on several occasions during the inspection. The sluice rooms contained very hot water and items that could pose a risk to people who used the service.

Not ensuring risk was assessed and steps taken to mitigate risk to ensure people received safe care and treatment was a breach of regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people had not always received their medicines as prescribed. Two people who used the service had not received pain relief patches in a timely manner. In one case this was due to nursing staff omitting to enter the controlled drugs patch onto the person's medication administration record (MAR) when they were admitted to the service. This was identified during the inspection and mentioned to nursing staff straight away to address. For another person this was due to large gaps in the administration record. For example, the person was prescribed the pain relief patch every 72 hours but, on 10 occasions the application varied

between 63 and 80hours. Four people had not received their medicines for various days due to stock management and two people were late in starting medicines that had been delivered but not organised to be administered in a timely way. We observed a medicine pot with a tablet inside had been left by staff in the bedroom of one person; this meant they had not witnessed the person take the medicine before they signed the MAR. There were some minor recording issues and we found medicines were not stored at an appropriate temperature in the nurse's office; often the temperature of the room was recorded as 29 degrees centigrade when the optimum temperature, as recommended by manufacturer's for safe storage of medicines, was 25 degrees centigrade. Some people who used the service were prescribed oxygen therapy, however, statutory warning signs were oxygen was used and stored were not in place.

Not ensuring people received their medicines as prescribed was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found parts of service required cleaning and there were some concerns regarding infection prevention and control. For example, some equipment used in the service was stored inappropriately; we saw bed rail protectors stored under beds which harboured dust and a nebuliser was stored under a table covered in dust. Some wheelchairs required cleaning as they were marked with splashes of liquid and food debris. Some bed rail protector covers were perished which meant they could not be cleaned properly. There was a smearing of faeces on a tap and a tile in one of the communal toilets and commode seats, lids and toilet seats were in need of cleaning. Some carpets in bedrooms were stained and in need of cleaning. The two sluice rooms were cluttered with items on the floor and the rooms needed sorting and cleaning. Staff had a good supply of personal, protective equipment such as gloves, hand wash and paper towels. However, we saw communal hand wash areas lacked signs which would provide, staff, visitors and people who used the service with information about good hand hygiene practice. We also observed one member of staff, with no gloves or apron, walk past the office carrying a used and uncovered urine bottle. This was mentioned to the registered manager to address with staff.

Not ensuring the service was clean and people were protected from the risk of infection was a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training and in discussions, demonstrated they were aware of policies and procedures in alerting and referring allegations of abuse. However, we found staff had not always followed safeguarding policies and procedures in practice. For example, when a person who used the service had made an allegation of abuse and when unexplained bruising was noted on another person's arm. Staff had recorded these incidents in the care files of the people involved, but had not reported these to the registered manager so action could be taken.

Not ensuring people were protected from the risk of harm and abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been several days when there were insufficient nursing staff on duty to provide the necessary care and support to people. This had impacted on the admission and assessment process, the planning of care and, in some instances, on the delivery of care for specific people who used the service. There was also an over-reliance on agency nurses to fill gaps in the staffing rota. For example, from 1-14 March 2017, there had been 13 nurses' shifts covered by agency staff. This impacted on the continuity of nursing support for people who used the service. The registered provider told us they always tried to ensure the same agency nurses were requested to cover the rota. There were sufficient care and ancillary staff on duty.

Not ensuring there was sufficient qualified and experienced staff at all times was a breach of regulation 18 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed staff recruitment with the registered manager and they described the action they took to ensure full employment checks were carried out prior to new staff starting work in the service. These included an application form, references, an interview and a check with the disclosure and barring service (DBS) to ensure the candidate was suitable to work in care settings.

Despite the concerns we found in relation to providing a safe service, people were happy with the care they received. They said they felt safe and received their medicines on time. Comments included, "Yes, I get hoisted well; I have got a buzzer system", "I know if I press the buzzer, help is there for me", "I know there is somebody here to look after me", "There's a safe building and the staff check on me regularly", "All the staff are great" and "I feel safe as there are carers around." Comments about medicines were, "They are on time and I get pain relief when needed" and "I am asked if I need pain relief." There were mixed comments about staffing numbers. Some people said staff responded to call bells within 10 minutes whilst others felt there was a staff shortage at times. Comments included, "No, sometimes they are short staffed", "I don't think so [sufficient staff]; they don't always come when I press the call button at night", "There's a call button in my room and most times they are pretty quick - 10 minutes" and "As far as I am concerned, there are enough staff."

Visitors said, "When we use the call button they come within minutes" and "She can go to the toilet on her own so doesn't have to wait for staff; it feels short-staffed at weekends." The registered provider told us staffing levels remained the same at weekends as during the week. One visitor went on to describe incidents when they had observed people having to wait long periods for support to use the toilet at weekends. This was mentioned to the registered manager to check out with people who used the service.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the application of MCA was inconsistent. Some people had restrictions in place such as bedrails, sensor mats and lap straps; however, their capacity to make these decisions had not been fully completed. Also the decision to provide bed rails, sensor mats and lap straps had not been discussed and recorded as in their best interest as the least restrictive option for people. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered provider was working within the principles of the MCA for most of the people who used the service. Applications for DoLS had been submitted to the local authority and were awaiting assessment. However, we had concerns about one person who it was recorded was distressed and tried to leave the building but contact with the local authority had not taken place to discuss if an urgent DoLS was required.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We saw people who used the service had access to a range of community health care professionals. However, we had concerns regarding how some people's health care needs were met in a timely way. During a tour of the environment, we noted one person had very dark urine in a bag attached to a stand and we mentioned this to the registered manager to address. On checking, the person was found to have an infection and their GP was contacted for advice and treatment. The concern is that had this not been pointed out by the inspector, treatment for the person would have been delayed. There were significant concerns regarding the management of one person's falls, weight loss and catheter management. Nursing staff had not removed the catheter as directed at a multidisciplinary team (MDT) meeting. The person went on to pull the catheter out causing trauma. Fluid intake records for the person were inconsistent and some falls were recorded in daily records rather than accident records and not passed on to appropriate people.

There were other concerns for individual people who used the service. These included pressure relief and monitoring, recording of wound care, the management of a percutaneous endoscopic gastrostomy (PEG) site for one person, diabetes management for one person and mouth care for another person. A visitor told us they had to adjust their relative's pillows to ensure they were seated in the correct upright position as they had difficulty breathing and was on oxygen therapy. The visitor felt their relative required more frequent checking. On the second day of the inspection at 12 noon, the person's fluid chart showed their last drink was given at 6am and the last entry on their pressure relief chart was at 6.30am. A visitor told us their relative was at risk of pressure damage and had an airflow mattress when they were in hospital as they had

developed sore areas. They said their relative had been admitted to Rossmore Nursing Home five days ago and they had mentioned the need for an airflow mattress twice but it had not been provided yet.

Not ensuring people receive safe care and treatment in a timely way is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

In discussions with people who used the service, they told us staff supported them to make choices and decisions and they had access to health professionals when required. Comments included, "I am very verbal [tell the staff what I want]. I have a keyworker and he will take me out; I get up and go to bed when I choose", "They always ask; I've never known them do anything without asking" and "They include me in whatever plans they have; it is always my choice." One person told us they would like to be more involved with the planning of their care and said they were not always consulted. Other comments included, "I've seen a doctor about my leg, and seen a dentist, optician and chiropodist" and "He [doctor] is there when needed." Relatives said, "She is dependent [on staff]; they feed her, give her medicines and look after her" and "I visit every day and I'm happy with the care." One visitor told us they were grateful that staff had recognised and acted upon an important health issue for their relative.

We found people's nutritional needs were met. Most people who had nutritional concerns had these identified by using a recognised nutritional screening tool/assessment. When concerns were identified, people were referred to a dietician. There were some exceptions when we found several people admitted to the step-down service had not had an assessment of their nutritional needs completed in a timely way; this has been mentioned in risk management in the 'Safe' domain. People's weight was monitored to ensure this remained within acceptable levels for their height and build. The menus provided people with choices and alternatives and in discussion with the cook, it was clear they had an understanding of special diets and received information about people's nutritional needs from care and nursing staff. We saw the cook made fortified milkshakes and placed these in the fridges on each floor for staff to provide to people. On the day of inspection, we saw one of these was unused. We observed staff supporting people to eat their meals in a sensitive way. People who used the service gave very positive comments about the meals provided to them.

Staff confirmed they felt supported by the registered manager. There was a plan to start individual supervision meetings where staff could discuss training and development needs and issues relating to their key worker role. Clinical supervision for nurses had been arranged to be carried out by a senior nurse within the registered provider's organisation. The registered manager confirmed there was to be training in supervision to ensure those delivering it had up to date skills. Staff stated training had improved significantly since the new registered provider took over the service. They described recent medication, catheter management and dementia care training and said the latter had been instrumental in changing their perceptions about how to support people living with dementia. A staff development analysis had taken place and the training record indicated gaps in most areas but these had been identified and several courses had been planned. The areas of staff supervision and training will be followed up at the next inspection.

It is recommended the registered provider follow through with training and supervision plans to ensure that identified gaps are addressed quickly.

The new registered provider had plans in place to refurbish the service and this had just started at the beginning of February 2017 with the roof and exterior of the building. The interior works will take into account the needs of people who used the service. The plans in place will significantly help to provide a better environment for people who used the service.

Requires Improvement

Is the service caring?

Our findings

We found some areas of the service required improvement to ensure people's privacy and dignity were promoted. For example, white boards in bedrooms on the stroke unit had personal information on display regarding people's health, nutritional and physical issues. This included information such as 'right sided weakness', 'diabetic', 'textured E diet', 'do not leave drinks by bedside' and the numbers of staff required for assistance. In one person's bedroom we saw the blinds were broken and in another, the curtain rail was hanging off and curtains would not close; these issues posed a risk to the occupant's privacy and dignity. Another person required additional support to ensure their privacy and dignity was maintained. A personal letter dated January 2017, from HM Department of Works and Pensions and addressed to a person who used the service was found in the activities cupboard. The activity coordinator told us they supported the person in reading and responding to letters. However, this should have been returned to the person or, if in agreement by the person, held securely by the registered manager.

We saw the lunchtime experience on the second day of the inspection was very poor for people sitting in the lounge; for a lot of people mealtimes are the highlight of day and should be a sociable and pleasant experience. The dining room, attached to the lounge, was inaccessible as work was being undertaken at one end of the room; however the doors were open at that end and also at the opposite end in the lounge. This created a thoroughfare for workers bringing items from the front to the rear of the property. Both front and rear doors were ajar which meant there was a cold draught through the lounge during lunch and meals became cold quickly. There was the loud noise of drills and other equipment being used during lunch.

We saw there were communal toiletries in bathrooms and on a trolley, and a 'pads room' had boxes of continence aids on shelves that were not labelled with the person's name for whom they were prescribed. Staff were unable to tell us which aids were for specific people and in a staff meeting dated 7 December 2016, it was recorded staff were using the wrong continence aids for people. Staff told us the toiletries were used for people who ran out or who were admitted without any products. We spoke with the registered manager about labelling these products for individual use when they were required. The registered manager was unsure who the products in the communal bathroom belonged to. The registered manager told us they would address the continence aids issue straight away and ensure the boxes were labelled correctly and only used for the people they were prescribed for.

People told us staff were kind and caring and respected their privacy and dignity. Comments included, "The day time staff are brilliant, you can have a laugh and a joke with them; they are caring." The person mentioned three care staff by their first names and said they were 'great'. Other comments included, "They are all different, some I like and some I don't", "Staff are wonderful, really kind and they answer the call button in five minutes", "The staff are top class; they say to press the buzzer if I need anything", "My family and son come to visit; I have privacy when needed" and "They're very pleasant, friendly and caring. I use the buzzer at night and staff are here in five minutes." Two people made a negative comment about a member of staff and about an inconsistency in ensuring call bells were to hand at night; these points were mentioned to the registered manager to address.

Visitors had very positive comments about the staff team, their kind and caring approach with people and how they were involved and included in their relative's care. "They [staff] are very good. They all look after her and all call her by her first name; anything she wants they get", "Yes, they seem helpful, polite and cheerful; if you ask anything they tell you", "Yes, they do consult us; we are always asked our views and are given choices. The staff are very helpful and they respect the patient and family", "I always found the staff to be caring and kind" and "The staff are always willing to listen to any questions we have." The person went on to describe the support the family received from staff during a bereavement last year.

Health professionals also had positive comments about the staff approach. They said, "There are some very caring staff", "Staff generally promote autonomy and always listen to individual's needs" and "Senior carers always promote privacy and dignity when we visit."

We observed staff were attentive and there was positive interaction between them and people who used the service. We observed care staff provided explanations to people prior to completing tasks. When assisting people to walk, staff were patient and used encouraging and positive language. We saw a member of staff sit with a person, chat to them about the day's news and the benefits of wearing comfy footwear and gave them a hand and arm massage. Other staff were observed talking to people about television programmes, their family, refurbishment and the weather. We saw the atmosphere in the stroke unit was lively. We overheard one person complain of pain and staff asked them if they required pain relief; staff reported this to a senior care worker. During the afternoon, we observed staff provided hot and cold drinks to people; they asked each person in turn whether they wanted a hot or a cold drink and served people individually. One person living with dementia continually walked up and down the corridors and into offices to see and chat to staff. We saw staff were patient and provided positive support and redirection for them, helped to calm the person when they became upset and encouraged them to sit and have a drink.

People were provided with information on notice boards. For example, the date and weather was written on a white board in the lounge. The day's menu was pinned to boards at both ends of the dining room, although this could have been in larger print or pictorial format to assist people with specific needs. There was an activities board with a description of the day's events. There were staff photo boards although these were not fully up to date and was mentioned to the registered manager to address. There was a 'service user's directory'. This provided people with information about what to expect regarding their care and treatment, the aims and objectives of the service, activities, a sample of a 'relatives and residents' meeting and how to make a complaint.

Apart from the white boards in some people's bedrooms mentioned above and addressed during the inspection, we saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office, the senior care office or the registered manager's office. People's reviews were held in their bedroom or a quiet area. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The registered provider was also registered with the information commissioner's office, a requirement when computerised records were held. Staff records were also held securely in the administrator's office.

Inadequate

Is the service responsive?

Our findings

We found concerns with the admission process into the step-down facility and whether this was completed in a way that met people's needs. The step-down facility was meant to assist with hospital discharges for people medically fit and awaiting a care package at home. For example, in one person's care file it stated staff were unaware they were due to be admitted and had no information about them when they arrived at the service. Staff had to contact the hospital ward for information. Another person was admitted with complex needs and was readmitted to hospital a few days later.

We found concerns regarding the lack of assessment and care planning information available when people were admitted to the service, especially to the step-down facility but also to the stroke unit, and a lack of evaluation and update to plans of care when people's needs changed. Out of seven care files we assessed for people in the step-down facility, four had multiple health needs identified but no care plan. For example, one person had needs associated with mobility, falls, nutrition, personal care, confusion, chronic obstructive pulmonary disease needing oxygen therapy, pressure damage, skin tears and continence support. Their care file consisted of a moving and handling assessment and a falls risk assessment completed on the day of their admission. There were two wound assessment charts, one identifying grade two pressure damage and another referred to a skin tear. There were no wound care plans and no care plan at all to guide staff in how to meet their needs in a person-centred way. One other person had a basic care plan but their needs had changed and these were not reflected in the documentation.

One person in the stroke unit was admitted with multiple needs including paralysis of their left side, communication difficulties, chronic pain and depression. Their skin was intact but bruises were evident and detailed in a body map. They required a normal diet and fluids but with supervision. There were no care plans in place for the person's complex needs. Similarly another person was admitted with complex care needs in relation to catheter management, mobility, falls, nutritional intake, weight loss, swallowing, skin integrity risk, agitation and confusion. The care plans had minimal information about how the person's needs were to be met in a person-centred way. The care plans were not updated following significant changes. There was no care plan for the person's agitation, confusion and disorientation and no clear plan for falls. The person was a high risk of pressure damage but there was no care plan or pressure relieving mattress insitu. The catheter management and personal care plans were poor and did not contain sufficient person-centred information. A person in the main nursing unit had a poor care plan for the management of their diabetes.

These issues meant staff did not have important information about people's needs, how to deliver person-centred care and how to respond to changes in need. Some health professionals told us that because care plans were not completed thoroughly and documentation was not always evaluated, this had resulted in tasks not being completed.

Not ensuring people's needs were assessed and not designing care or treatment to ensure those needs were met was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of coordination, communication and recording when the responsibility of care was shared between health professionals involved in people's care and treatment. We were told by therapy staff there had been some inconsistencies with nursing and care staff in the delivery of rehabilitation care plans, monitoring of fluid intake, passing on important information and ensuring service users all had call bells in reach. This was confirmed in assessing records, observations of practice, attendance at a multidisciplinary team (MDT) meeting and talking to people who used the service. For example, information about one person's multiple fall history had not been communicated to therapy staff, and nursing staff had not followed instruction regarding the removal of the person's catheter. Nursing staff were not prepared for the MDT meeting and important information and documents were not readily available. Comments from health professionals included, "This [staff following instructions] is variable. It has improved with training but things have to be checked and closely monitored. When we ask for monitoring charts, these are not always completed."

Not ensuring people received coordinated care between people who share responsibility for care and treatment was a breach of regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with told us staff looked after them well and responded to their needs. They said, "Every step of the way they ask and my family are made welcome" and "They bring my dog in for visits which makes me happy." Visitors said, "It's lovely, absolutely lovely. [Name] has come on so well; they have only got on so well because of the staff. [Name] is always smartly dressed and is taken out by staff." One visitor told us staff had not responded in a timely way to their request for a softer meal option for their relative. They said the meal request had not arrived before they were due to leave so they were unsure if their relative had received the softer option. This was mentioned to the registered manager to address.

We saw there was a programme of activities for people to participate in and therapy plans for those people in the stroke unit. People confirmed they could join in activities if they wanted. Comments included, "I don't take part in activities by choice; singers come in but they are more for elderly people. I can go out with my key worker", "I play bingo and dominoes and I have been out in the bus", "You can join in if you want to", "I made scones yesterday and I listened to music on Monday" and "I've not been involved in any as I've only been in a few days." The activity coordinator worked Monday to Friday 10am to 5pm and occasionally helped with caring tasks such as supporting people to use the toilet. They described the activities available as craft work, games, bingo, dominoes, quizzes, visiting entertainers, hand and nail care and seasonal activities such as gardening. Records were made of the activities each person participated in. There were fortnightly trips to a social club for up to nine people. People in the stroke unit had the opportunity to attend arts and crafts and a baking group in addition to therapy sessions.

We observed two people in a shared bedroom had one television. One person was sat in a chair and was able to see and hear the television. The other person was in bed and was unable to see the television. They told us they would have liked to have seen it but were satisfied if they could hear it. It was difficult for both service users' needs to be met in this situation and we mentioned this to the registered manager to try to address with the use of two televisions and headphones.

The registered provider had a complaints policy and procedure, of copy of which was held in the statement of purpose and 'service user's directory'. This detailed who to refer complaints to, whose responsibility it was for investigating them and timescales for acknowledgement and completion. The policy and procedure was not on display in the service which meant people may not have information to hand about the process. However, we overheard a relative speak to the nurse in charge about some concerns and the nurse recorded the issues and said they would try to address them. People who used the service said they felt able to raise

concerns if required and some said they would speak to their family first. Comments included, "[Registered manager's name] is approachable; I've complained a lot about night staff", "You could tell any of them; every single one is so kind", "I told [staff name] my last room was noisy and they moved me straightaway" and "I would tell my family who visit." Some relatives provided the names of individual staff they would speak with and said they had no concerns about raising issues as staff were approachable.

Inadequate

Is the service well-led?

Our findings

Throughout this inspection report we have indicated concerns and a number of regulations have been breached. Failure of the registered provider to comply with specific regulations 9, 11, 12, 13, 17 and 18 is a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We had concerns with the overall governance of the service. The service had a registered manager in post and there was a structured tier of senior managers. The registered manager told us a director of the service visited every two weeks; this was confirmed in a discussion with the director. However, there was no system in place to evidence senior managers completed a tour of the building, checked relevant records, spoke to people who used the service, relatives and staff or completed audits to assure themselves of the quality of the service provided to people.

The assessment and admission process to the step-down facility required improvement to ensure this was completed in a more effective way. People had complex needs which had not always been assessed and planned for appropriately. Whilst understanding the need for a quick discharge into step-down beds to free hospital beds in times of pressure, the lack of clear assessment protocols or the following of them placed people at risk of receiving inadequate care, treatment and support. The registered manager did not have a clinical background and nursing staff completed the admissions process. There was no deputy manager and no clinical lead to support the registered manager.

We saw there was no structured quality monitoring system in place that ensured identified shortfalls were addressed in a timely way. There had been an infection prevention and control audit in December 2016, but the action plan with timescales for completion was not available. We found concerns with the clutter and cleanliness of sluice rooms which was indicated on the audit; these issues had not been addressed by the date of the inspection. There had been a full medicines management audit completed in November 2016. There were also in-house medicines audits, some of which had been completed a day before the inspection but these had failed to pick up issues with stock management. There had not been a weekly audit of the controlled drugs register, which may have identified the time issues in the application of pain relief patches to people. There was a weekly worksheet for maintenance personnel to carry out safety checks but it was unclear when issues were identified, when they were addressed. There had not been any check of housekeeping logs to ensure standards of cleanliness were maintained. There had not been any surveys carried out since the new registered provider took over the service apart from four visiting professional's questionnaires dated January 2017. The registered manager told us they had not seen them and was only informed if there were any major issues.

We had concerns about shortfalls in communication between staff within the service and between staff and the therapy support service. Information had not been passed on to therapy staff which could potentially impact on the treatment plans they developed. For example, evidence from a multi-disciplinary team meeting indicated therapy staff had not been informed of the multiple falls sustained by one person.

Evidence from interview with key staff indicated they were not aware of or informed about aspects of a person's needs and changes in care. Evidence from interview with the registered manager indicated they were not made aware of safeguarding incidents and accidents.

We found accidents were collated and documented but there was no analysis and action plan to learn and prevent a reoccurrence. One person had two accidents with a shower chair, five days apart which resulted in bruising to their leg. There was no analysis of the first accident and action taken to prevent a reoccurrence.

Not having systems in place for good governance is a breach of regulation 17 (1) (2) (a) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns about effective recording within the service. There were significant deficits in recording the assessment and care plans for people occupying step-down beds. Therapy staff recorded treatment plans and information about people on a computerised system, however nursing and care staff within Rossmore Nursing Home did not yet have access to this information. There were multiple locations for nursing and care staff, and the therapy team to record information, which made it confusing and meant there was a risk of it being overlooked. Nursing staff had recorded information about people's needs on handover sheets or passed on information verbally in handovers but on occasions omitted to record the information in daily notes or nursing notes. We found the recording of monitoring charts for fluid intake was confusing and inconsistent. Staff did not 'total up' intake and output and there was no optimum amount of fluid indicated for care staff to encourage service users to aim for. There were gaps in the charts for monitoring food and fluid intake, bathing, bowel motions and standing to relieve pressure. We saw there was an inaccurate recording of what one person had eaten for their lunch during the inspection. Some accidents and incidents were recorded in daily notes and not on accident records, which may mean the registered manager was unaware of them and they may not be included in analysis and action plans to address them or learn from them.

Not maintaining accurate, complete and contemporaneous records is a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During a discussion with the registered manager, they were clear about their registration responsibilities regarding notifying the Care Quality Commission (CQC) about incidents which affected the health and welfare of people who used the service. We had received notifications when people had serious injuries or when they had died. However, we had not received notifications for several incidents that were reported to the local safeguarding team. The registered manager became aware of them in February 2017 but CQC were not informed.

Not notifying us of incidents which affected the safety and welfare of people who used the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the registered provider reminding them of their responsibility regarding notifications to CQC.

Following the inspection, we received an action plan and have received weekly updates on progress. The registered provider also agreed to a voluntary suspension of the use of the step-down beds until systems could be improved. This has shown us the registered provider has taken our concerns seriously and has taken steps to address the shortfalls. Weekly meetings have been arranged between senior management, the registered manager and therapy staff in an effort to improve communication and ways of working.

People who used the service and their relatives had positive comments about the registered manager.

People were aware of their name and said they could raise issues with them if required. Health professionals also stated the registered manager was approachable. Staff told us they felt supported by the registered manager. Comments included, "They are the best. If there is a problem, they are behind us, and anything we want to say, we can go to them."

Relatives said they had been informed about the changes made by the registered provider. We saw in the minutes of a meeting held in October 2016 that people who used the service had been introduced to the registered provider's Chief Executive Officer and another of the directors. They had the opportunity to express their views about the service. One person who used the service told us, "They are putting a bigger smoking area in and it will be heated."

There had been a meeting for staff in December 2016, which provided updates to them regarding changes made by the new registered provider. Staff told us they were confident that the environmental updates, and other changes such as training and staffing, would improve the service for people.