# Embrace (UK) Limited

# Rosewell

## Inspection report

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Date of inspection visit: 20 July 2015
Date of publication: 16/09/2015

## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 20 July 2015 and was unannounced. When the service was last inspected in March 2014 there were no breaches of the legal requirements identified.

Rosewell is registered to provide personal and nursing care for up to 96 people. Three areas of the home named Rose, Sunflower and Bluebell accommodated people with personal care and nursing needs. The Farmhouse area accommodated people with personal care needs only. At the time of our inspection there were 70 people living in the home.

There has been no registered manager in place for over six months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The staffing levels were not sufficient to support people safely. Staff were rushed when undertaking their duties.

# Summary of findings

Staff we spoke with across all of the areas said there were not enough staff on duty to meet the needs of the people. They also told us that staffing levels had recently been reduced.

People were not cared for in a safe, clean and hygienic environment. Some areas in the home were not clean or safely maintained.

The lunchtime service was not organised which resulted in food not being consistently served at an appropriate temperature.

Staff were not consistently supported through an effective training and supervision programme.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The service had a programme of regular audits, however audits to monitor the completion and accuracy of records were not completed and other audits were not always effective.

We observed staff treating people with kindness, but there was limited social interaction with people. Feedback from people who used the service and relatives advised that the care was good most of the time and the care staff really wanted to provide the best care they could. They thought they were being hampered by being short staffed at certain times.

People's medicines were managed and administered safely. Some improvements were required on checking stock balances for some prescribed medicines.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

Staff received training and understood their obligations under the Mental Capacity Act 2005 and how it had an impact on their work. Within people's support plans we found the service had acted in accordance with legal requirements when decisions had been made where people lacked capacity to make that decision themselves. This meant people's rights were protected when they lacked capacity to make decisions about their care and support.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires improvement

The service was not always safe.

The staffing levels were not sufficient to support people safely.

People were not cared for in a safe, clean and hygienic environment.

Safe recruitment processes were in place that safeguarded people living in the home. Robust checks were made before people started working in the home.

**Is the service effective?**

Requires improvement

The service was not always effective.

Staff were not consistently supported through an effective training and supervision programme.

Staff understood the basic requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the need to gain consent from people using the service.

People had their physical and mental health needs monitored and had access to healthcare professionals according to their specific needs.

**Is the service caring?**

Requires improvement

The service was not always caring.

We observed staff treating people with kindness, but there was limited social interaction with people. Staff appeared to be task orientated and did not spend time talking to people.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people.

Feedback from relatives advised that the care was good most of the time and the staff really wanted to provide the best care they could

**Is the service responsive?**

Requires improvement

The service was not always responsive.

Assessments were not consistently reviewed regularly and whenever needed throughout the person's care and treatment.

The service took into account the person's capacity and ability to consent, and either they, or a person lawfully acting on their behalf were involved in the planning and review of their care and treatment.

A complaints procedure was in place and the manager responded to people's complaints in line with the organisation's policy.

# Summary of findings

**Is the service well-led?**

Inadequate 

The service was not always well-led.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

Where risks were identified, the provider did not consistently introduce measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale.

People were encouraged to provide feedback on their experience of the service.

# Rosewell

**Detailed findings**

## Background to this inspection

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

This inspection took place on 20 July 2015 and was unannounced. The inspection was undertaken by three 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.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas. 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 to us.

We spoke with 12 people that used the service, seven relatives and nine members of staff. We also spoke with the clinical lead, the deputy manager, the manager and regional manager. We also spoke with the local GP who was visiting the service on his weekly round.

We reviewed the care plans and associated records of seven people who used the service and the medicines administration records for 18 people. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires improvement

# Is the service safe?

## Our findings

The staffing levels were not sufficient to support people safely. The manager told us that staffing levels were assessed by following the "Staffing guidance for Nursing Homes – June 2009". The guidance was produced by the Regulation and Quality Improvement Authority. The guidance was used to ascertain the numbers of staff required based on people's needs. The manager told us that they had conducted a staffing level review in June 2015.

On the day of our inspection the occupancy level for each area; 18 people resided in Farmhouse; 13 people resided in Bluebell; 18 people resided in Rose; and 21 people resided in Sunflower.

Before our inspection, concerns had been raised about staffing levels, particularly at night time. The night time staffing level equated to six carers and two registered nurses. We were told by the manager that 24 people required two care staff to provide personal care and 29 people required two care staff for moving and handling purposes. On each floor there were people who did not need two care staff to deliver personal care but may need two for moving and handling purposes. This was considered by the manager as an adequate night time staffing level for the dependency level of the people who used the service. Feedback provided by one relative through the home's recent survey stated "there are not enough staff at times, particularly after 6pm when most people ask to go to bed." Another person told us "they're under-staffed. The call bell is never responded to quickly sometimes up to half an hour or more."

During the day there were not enough staff on duty to meet the needs of people. The Rose, Sunflower and Bluebell were allocated eight care staff during the 8am – 2pm shift. The cover reduced to six care staff from the 2pm – 8pm shift. The Bluebell and Farmhouse areas were allocated two care staff in each area through the day. Staff were rushed when undertaking their duties. Staff we spoke with across all of the areas said there were not enough staff on duty to meet the needs of the people. They also told us that staffing levels had recently been reduced. The rotas we saw showed they were staffed in accordance with the manager's dependency assessment level. Comments included; "There are not enough staff; you can see that from the way everyone is rushing all the time. It's 12.30 now and some people have only just been washed"; "There are not enough staff. If there was more staff we could actually answer call bells quickly and help people with personal care, but it's too demanding, too rushed" and "At the moment I wouldn't put my nan in here if she needed care, because of the staffing levels."

People who used the service provided mixed feedback regarding staffing numbers. Comments from people who used the service included; "If I ring the bell, they come pretty quickly" and "There's no point ringing the bell, they take so long to come. How would you like to wait 40 minutes to go to the toilet?" Throughout the inspection call bells rang almost continuously. The manager told us that the call bell system did not have the facility to enable them to audit the time it took staff to respond to call bells. We spoke with one person who told us they were worried during the morning when they were in the lounge and needed to go to the toilet. There was no access to call bells within reach in the lounge. We observed the person calling out three times and they were becoming anxious. We found a member of staff who then provided the support the person required. Another person told us "there are not always two of them when I have to be hoisted and there is sometimes quite a long wait to be helped to the toilet as I need a hoist and two carers."

The manager told us that the current staffing levels were in accordance with the assessed dependency needs of the people who used the service. There is an apparent discrepancy of people's feedback on staffing levels and the guidelines used by the manager. Our observations also identified concerns with staff being unable to respond to people in a timely manner. The regional manager told us they were experiencing a challenge in recruiting staff and they have to use agency staff to backfill the current staffing vacancies in the service. They were in the process of trying to recruit additional nurses and care staff. They are also currently reviewing how best they can use their resources to ensure people's needs are met at peak times. They told us staffing allocation and staffing levels are reviewed on an on-going basis. Where the service was experiencing difficulties with a staff member's attendance appropriate action was taken.

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

Requires improvement

# Is the service safe?

People were not cared for in a safe, clean and hygienic environment. Several armchair cushions were stained, and one armchair had torn material under the seat cushion. The inside of the microwave in the Bluebell kitchenette was rusty. There were cleaning products in an unlocked cupboard under the sink for anyone to access. The cupboard was very dirty inside. Odours were evident in several bedrooms throughout the day. Staff said they were aware of the smell. Several carpets appeared hazardous as they were worn and some were stained. In an attempt to secure the carpet, strips of tape (sticky to touch) were in place at the entrance of the dining room in Bluebell. In this area we also saw dust and used tissues behind people's beds. Some commodes were dirty, with a build-up of grime on the legs and base of the equipment. One relative had commented in their feedback to the service; "We do not wish to be consumed with grimy surfaces, spillages, messy floor spaces, clothes and belongings mis-placed or lost. Having said all this we do appreciate your able staff's efforts to make x's home as comfortable as possible." We reviewed the infection control audit conducted in March 2015 and none of these issues were identified. As an example the furniture and carpets were recorded as being in a good state of repair and were clean and free from rips and tears. The regional manager told us they intended to incorporate a refurbishment programme in the future.

An incident had occurred in May 2015 where the security arrangements did not ensure the safety of one person. They left the building through a door that had a faulty keypad and the fire release mechanism had been turned off which allowed the person to leave without an alarm being raised. Owing to their medical condition, the person should not have been able to leave the building without assistance. They left the building and walked along the main road and had fallen which resulted in them being taken to hospital. The issue has now been rectified.

**This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

To support a person's needs, risk assessment documentation was contained in each person's care plan. These included assessments for their specific needs for eating and drinking, moving around and falls, bed side rails, pressure sore risks and continence. Assessments were reviewed and updated, mostly on a monthly or three monthly basis. Although care plans contained risk assessments and staff guidance on how to keep the person safe we found that some care plans that did not consistently provide enough detail to inform staff how they should achieve this. One person had fallen six times in the past seven weeks. The person had a frame to assist them when mobilising but often forgot how to use it. Staff documented that when the person became anxious they would walk "with intent." The plan informed staff to; "Remind x to use the frame and talk to them." There were no further instructions on how to try and reduce the person's agitation. During our inspection we observed the person becoming agitated and calling out to staff. They tried to stand up and walk without a frame but no staff were available to reassure them or to remind them to use their walking aid. This meant there was a continued risk of the person falling.

People were protected against the risks associated with medicines because there were appropriate arrangements in place to manage medicines. People's medicines were managed and they received by people safely. We observed a medicine round in two areas of the home. People were receiving their medicines in line with their prescriptions. Staff administering the medicines were knowledgeable about the medicines they were giving and knew people's medical needs well. They checked people had drinks and gave assistance when required. Staff completed medication administration records to document when people had taken their medicines.

We were told by the clinical lead nurse that nobody at the home self-administered their medicines. Assessments had been completed and where people had capacity to make their own decisions had chosen not to self-administer. We saw that PRN plans were in place. PRN medication is commonly used to signify a medication that is taken only when needed. Care plans identified the medication and the reason why this may be needed at certain times for the individual. Care plans confirmed how people preferred to take their medicines.

Appropriate arrangements were in place in relation to obtaining medicine. Medicines were checked into the home and were generally recorded appropriately. We did note a couple of exceptions where new stock had been received and carried forward amounts were not always

Requires improvement

# Is the service safe?

recorded, amounts actually received were not always recorded or where variable dosages were prescribed, the actual dosages were either not recorded, or it was difficult to read on the MAR sheet.

Medicines were stored correctly in locked trolleys and a treatment room contained additional storage, a controlled drugs cabinet and a fridge. To ensure medicines were stored at the correct temperature daily temperatures of the room and the fridge were checked and recorded.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant's identity and their employment history.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The manager reviewed all incidents on a monthly basis to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up and support plans adjusted accordingly. One person had experienced a fall which resulted in them being taken to hospital. A full investigation was conducted and preventative measures to mitigate future risks were recorded.

Staff we spoke with demonstrated a good understanding of how to recognise and report abuse. All staff gave good examples of what they needed to report and how they would report concerns. Staff told us they felt confident to speak directly with a senior member of staff and that they would be taken seriously and listened to. They also advised that they would be prepared to take it further if concerns were unresolved and would report their concerns to external authorities, such as the Commission.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

Fire risk assessments had been completed for people, and there were personal emergency evacuation procedures for individuals in place. This meant that staff had the information they needed to keep people safe in the event of a fire.

**We recommend the provider reviews the level of detail held in each person's risk assessment and staff guidance on how to keep each person safe.**

Requires improvement

# Is the service effective?

## Our findings

Staff were not consistently supported through an effective training and supervision programme. The provider's supervision of staff policy was not being adhered to. The purpose of staff supervisions were "to improve the quality of staff support by providing enhanced job satisfaction, better training opportunities and career development" and were meant to be conducted every 4 – 6 weeks. Some staff told us they had received supervisions recently, but this was not consistent. This position was reflected in the staff records. A number of staff had only received one supervision this year. The lack of supervision meant that staff did not receive effective support on an on-going basis and training needs may not have been acted upon.

New staff undertook a period of induction and mandatory training before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, dementia care and first aid. The training records in some cases demonstrated that staff mandatory training was out-of- date and required up-dating. An internal audit conducted by the service in June 2015 also identified that practical training compliance was poor.

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

The lunchtime service was not organised which resulted in food not being consistently served at an appropriate temperature. Some people chose to sit in the communal dining area whilst others chose to stay in their rooms. There was a choice of main meals and people had chosen the previous day what they would eat. Staff said that if people decided they didn't want their original choice any more the kitchen would offer an alternative. In the Rose area the meals were transported from the kitchen on a trolley which was not heated. Owing to the number of people being served lunch in their bedroom and the time it took to reach them some people had received lukewarm or cold food.

People said the food was "Not so good. The lamb was lovely, but the chips were soggy and cold." People said hot drinks were not always served hot. One relative said; "The Horlicks was stone cold the other evening. I had to go and ask for it to be heated for my relative." There were jugs of squash available throughout the day and staff regularly offered cold drinks to people. However, at 11.20 we observed two people discussing whether they were going to be offered a cup of coffee that morning. When coffee was served later in the morning we were offered a drink. The drink was tepid and there were still a number of people who had yet to be served.

**This was in breach Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff were able to demonstrate an awareness of a change in people's needs. One person's care record showed that they had recently been assessed by the Speech and Language Therapist. Within the healthcare professional notes of the person's care plan, there was guidance on the specific care staff should provide to meet the person's care needs regarding the consistency of their diet. The food was served in accordance with the information and guidance in the care plan.

When people were having their nutritional and/or fluid intake monitored, charts had been fully completed. There was a planned amount for people to eat and drink and where the amount had not been met the previous day this had been highlighted on the current day's chart. The handover sheet provided to staff highlighted which people should be encouraged to drink. Staff knew why people were having their food and drink monitored and understood the importance of maintaining accurate documentation and people maintaining their nutritional and fluid intake.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We saw information in people's support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The manager confirmed that DoLS applications had been made and they were waiting for the outcome from the local authority.

People's rights were protected when decisions were made on their behalf. Mental capacity assessments were conducted on specific issues. An example of this included

Requires improvement

# Is the service effective?

bed rails assessments. Where people were unable to make decisions, the person's representative and health professionals were involved in best interest meetings. Involving the person's representative enabled the service to take into account the person's wishes, feelings, beliefs and values.

Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the need to gain consent from people using the service. Staff told us they had completed training on the legislation.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs. On the day of our inspection, a GP was visiting some of the people living in the home. They discussed with the clinical lead each individual's needs and changing circumstances. The GP was complimentary about the quality of care provided. They believed the service had improved with good leadership. They told us; "Communication is usually good. Staff are usually proactive about reporting and escalating issues, concerns and changes." We also saw records that people had access to other external health services such as optician and chiropodist visits. We also viewed referrals being made to a Speech and Language Therapist and a Physiotherapist.

Requires improvement

# Is the service caring?

## Our findings

We observed staff treating people with kindness, but there was limited social interaction with people. Staff focussed on their tasks and did not spend time talking with people, even when they were serving lunch. At times there was little or no description of the food being served. Food was just placed in front of the person and staff comments included "you've got scampi today" and "here's your dinner".

Throughout the day we observed some caring interactions between staff and people they were supporting, others were not. We heard staff speaking quite loudly about and to people. People were often referred to by their room numbers. One carer told a person "sorry I haven't got time to stop" and walked by when the person indicated they wanted to talk. A member of staff commented "I think we struggle to provide quality of care because we're so often short of staff."

Feedback from people who used the service and relatives advised that the care was good most of the time and the care staff really wanted to provide the best care they could. They thought they were being hampered by being short staffed at certain times. One relative felt 'the home was short staffed at times and that this did affect the care given when there were not enough staff.'

When people became upset or distressed we saw some staff reacting swiftly and provided reassurance. Staff interacted in a caring manner and got down to a person's level in order to talk to them. We observed one staff member sitting for a period of time with one person who appeared upset. They were reassuring them that there was not a problem and they were going to be quite safe.

People could be visited by their friends and relatives at any time of day. During our inspection, people's relatives and visitors came to the home. One person's relative told us they and other relatives were able to visit whenever they wished. Relatives comments included; "I am always contacted if x is ill"; and "I am eternally grateful for the care x receives."

People's privacy and dignity was generally respected. Staff knocked before entering the person's bedrooms and care staff were respectful when providing personal care. One notable exception involved a member of staff walking into a person's bedroom without knocking and not addressing the person before carrying out a task and leaving the room.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people choice and encouraged independence such as; "I try and get people to help wash themselves if they can, even if it takes a bit longer; it's good for them to keep doing things themselves."

People were given the opportunity to pass on their feedback in surveys that were sent out by the service. If they had and concerns people and relatives we spoke with would feel confident to approach senior staff. One relative felt they "would be listened to and that the home would do all they could to put things right."

Requires improvement

# Is the service responsive?

## Our findings

The service was not consistently responsive to a person's needs. Assessments were not consistently reviewed regularly and whenever needed throughout the person's care and treatment. We reviewed the management of pain for one person. It was not complete or detailed. The records stated; "Often anxious about the pain x will experience when staff attend to x." There was guidance to; "Chat to x and spend time necessary to keep x calm and relaxed." The pain care plan stated to give pain relief when required and this was prescribed on a regular basis. There was no evidence of regular pain assessments being completed to inform this plan. There was only one assessment of the level of pain experienced, dated 4 April 2015.There was no other detailed description of the pain or of the effectiveness of pain relief. The end of life plan stated that the person "wishes to be free of pain". The absence of appropriate assessments meant the person may receive inappropriate care or not receive support in line with their preferences.

The person's "this is me" information was dated 1 March 2015 and stated; "Prefers to get up before breakfast and sit in their chair". Owing to the person now spending most of their time in bed the person's care needs had clearly changed. Staff were aware of their changed needs, but the information in their room folder had not been up-dated. The person was moved with a hoist. Updated guidance for staff, following a diagnosis of a fracture stated "hoist to bedpan or to change." There were no further detailed instructions or guidance to ensure equipment would be used safely to meet the person's needs. This placed them at risk of not receiving the care and support they need, particularly with staff who were not familiar with the person's specific needs.

Another person's records contained statements regarding their challenging behaviour as they had been aggressive towards staff members. The planned interventions included; "Approach x in a calm manner, leave x for a while if not cooperative, then back and try again until x becomes compliant. There were no behavioural monitoring ABC type charts in place. An ABC chart is an observational tool that allows a service to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating and incorporate strategies on how best to deal with challenging behaviour. The person sustained an injury on 16 May 2015 when they were described as "scratching and spitting and kicking." It was reported they had injured themselves at the time. Staff told us that they had not received training for supporting people with challenging behaviours and were not aware of any change to the care plan or strategy for caring for this person following the incident.

We found that equipment that was not consistently being used in accordance with the person's specifications. One pressure mattress had a pump that required a setting according to the person's weight. The person weighed 73.8kgs on the 19 July 2015 and their mattress was set for a person with a weight of 130kgs. There was not a checking system in place to confirm how long the mattress had been incorrectly set.

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

The service took into account the person's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf were involved in the planning, management and review of their care and treatment. Care plans were written in conjunction with people or their representative and people had signed the care plans to indicate their consent. We spoke with one relative who had been invited to visit during the GP's weekly round in order to be involved in their relative's review. One person told us they were involved with their care plan and were aware of and agreed to the care they were receiving. They told us; "I haven't been here long, and I want to go home if possible, so the plan is to get me strong and more mobile. The staff encourage me to be as independent as possible and I wash and dress myself, but I would like to have a bath but the staff said I can't, although I don't know why. I've given up asking."

The care plan included people's preferences and detailed how people wanted to be cared for. For example one care plan detailed the type and style of clothes the person preferred. We saw the person sitting in the lounge and they were dressed exactly as the plan stated.

To ensure that their care was specific to their needs staff we spoke with knew how to refer people to external professionals when required, such as a dietician or tissue viability nurse.

Requires improvement

# Is the service responsive?

A dedicated activities coordinator was employed by the service. There was a structured weekly activities programme. This included one-to-one sessions with people in their bedrooms, film club, memory activities and gardening club. We observed people playing bingo in the main lounge on the ground floor. Those participating were engaged and responding positively to the interaction. People were laughing as it took such a long time for someone to win the full house. We were told that the activities were available for all to attend and people living in other areas of the home would be assisted to attend.

We received mostly a positive response from people about the activities provided in the service. One person told us about a dog that visits and comes round to see anyone who likes her. Another person showed us a photo of them with a barn owl and the keeper which had been taken in the home the previous week. They had a display of birds of prey which they said was really interesting. One person commented; "I haven't felt up to many of the activities, but I did go along for the singing the other day, which I really enjoyed." One person felt that the service could improve their activities. They told us; "I used to paint. I really enjoyed it, but I don't do it much now. There isn't too much opportunity, but I'm never happier than when I'm painting."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. On the day of our inspection people were visiting and also taking people out of the home for the day.

The provider had systems in place to receive and monitor any complaints that were made. During 2015 the service had received four formal complaints. Where issues of concern were identified they were taken forward and actioned. An example of this included the implementation of more robust risk assessment regarding a person smoking and providing the appropriate assistance to enable them to smoke outside the building. People said they would speak to the manager if they had a complaint. One person told us; "I've never had to complain. I don't want to make a fuss, but if I did I would go to the manager." Relatives said they would feel comfortable making a complaint if they needed to. One person told us; "I would be happy to raise a concern or make a complaint should it be necessary. I feel I would be listened to and the home would do all they could to put things right."

Inadequate

# Is the service well-led?

## Our findings

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The service had a programme of regular audits, however audits to monitor the completion and accuracy of records were not completed and other audits were not always effective.

The systems had failed to identify the shortfalls found at this inspection such as the concerns surrounding cleanliness, food service, the accuracy of the person-centred information and the lack of detailed staff instructions to assist people with their care and welfare.

The regional manager visited the home regularly. The visits were used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. The regional manager completed a 'monthly provider visit report'. This audit ensured the regional manager had undertaken regular monitoring and reviews of the service. Audits included; inspection of premises, record of events, complaints, care plans and medicines records. All were recorded and any actions noted would be followed up the following month. Records that we saw confirmed this.

Where risks were identified, the provider did not consistently introduce measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale. We noted that the health and safety calendar task list identified an action in June "to fit final exit key pads to prevent residents accessing the laundry" and the priority was listed as "high". This had not been actioned. The regional manager identified that all care plans need to be reviewed and completed on their new support format with a matrix completed by the clinical lead for the manager and regional manager to review. This aim was to improve the personalisation of their documentation. The target date set was 15 May 2015 and it had yet to be completed.

People were encouraged to provide feedback on their experience of the service. The manager held a residents and relatives meeting on 11 March 2015; prior to that the minutes were dated 8 July 2014. The March 2015 minutes demonstrated that concerns were raised of staff being under pressure during the evenings and that people cannot go to bed when they want. In July 2014 it was also raised that call bell answer times were too long.

Annual satisfaction surveys took place to help develop and improve the quality of the service. The last one dated was conducted in June 2015. There were 27 respondents to the questionnaire. Overall 55% rated the general atmosphere in the home as being good or excellent. Comments included; "I visit x most weeks. She is very happy and content"; "On the whole I'm very pleased with the service, staff are very helpful and pleasant": and "I am eternally grateful for the care x receives". Most people's concerns were a re-occurring theme of staffing levels and the call bell system. Feedback comments included; "under-staffed. The call bell system is never responded to quickly, sometimes up to half an hour or more"; "Rosewell definitely needs more staff; there are no call bells in the lounge"; and "not enough staff at times particularly after 6pm." Despite persistent concerns raised since July 2014 surrounding the call bell system and the staffing levels the issues had not been actioned by the service.

**This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The regional manager told us that the survey results will in the near future be shared with the people living in the home, staff and relatives. The regional manager provided a copy of the feedback comments and their proposed action plan to address the identified areas of concern.

The manager communicated with staff about the service to involve them in decisions and improvements that could be made; we found recent meeting minutes demonstrated evidence of appropriate management and leadership of staff within the service. Agenda items identified action items which needed to be taken forward such as the supervision plan for staff, keyworker roles, recording keeping and improving communication.

Views in relation to the management team in the home were mixed. Staff said they attended regular team meetings and were encouraged to attend and contribute to these. Staff said they were aware of some of the recent quality improvements to the service; for example "When things go wrong, they get picked up really quickly now. It's much better than it used to be." Some staff also said; "Morale has been quite bad recently; we're all tired, this is a demanding role"; and "I don't think it's improving, it feels like they don't want to spend any money to make it better." All of the staff

Inadequate

# Is the service well-led?

did say that they felt well supported by the manager and they could go to them with any queries or concern. They said the manager had a visible presence in the home and they were approachable.

The manager was aware of when notifications had to be sent to CQC and had submitted these as required. These notifications would tell us about any events that had happened in the home. We used this information to monitor the service and to check how any events had been handled. This demonstrated the manager understood their legal obligations.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Staffing levels were not sufficient to support people safely.**<br>**Staff had not received appropriate support, training and supervision to ensure the needs of all people in the service could be met.**<br>**Regulation 18(1),18(2)(a)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**People were not cared for in a safe, clean and hygienic environment.**<br>**Regulation 15(2)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br>**The provider did not ensure that food and drink was served at the appropriate temperature.**<br>**Regulation 14(4)(a)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The provider did not consistently assess the risks to people's health and safety during their care and treatment.** |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| | Regulation 12(1) |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider had a system to regularly assess and monitor the quality of service that people receive but this was not effective.<br>Regulation 17(1) |