Mr Azad Choudhry & Mr Aurang Zeb

Rosehill House Residential Home

Inspection report

Keresforth Road
Dodworth
Barnsley
South Yorkshire
S75 3EB

Tel: 01226243921

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 17 December 2018. The inspection was unannounced on both days.

We had previously inspected the home in December 2017 and rated it as requires improvement overall. Our key question of 'caring' was rated as good and other key questions were rated as requiring improvement. We found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the provider had failed to ensure they notified us of other incidents. At this inspection we found this had not improved.

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

The home provides care and support for people with residential needs and has a maximum occupancy of 27 people over two floors. On day one of our inspection 23 people were living at the home, on day two there were 24 people living at the home, one of whom was receiving respite care and support on a temporary basis.

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

We found failings in the oversight, monitoring and management of the service which meant people did not always receive safe care and support.

The management of risks was not cohesive or consistent. People did not always have individualised risk assessments in place and these had not always been reviewed regularly.

Medicines were not administered safely. We could not be assured these were always administered as prescribed or stored safely.

Mental capacity assessments and best interest decisions had not taken place for people living with dementia. Consent was not checked or recorded. DoLS applications had been made appropriately.

Staffing levels were sufficient, rotas were in place and gave consideration to staff skills. A dependency tool was used to asses staffing levels.

There was a regular programme of activities and people spoke positively about the activities co-ordinator however some people were left without social stimulation for long periods of time.

Staff received regular and appropriate training and supervision but had not received an appraisal within the last 12 months.

People's needs in relation to the protected characteristics of the Equalities Act 2010 were taken into account at pre-admission. People's communication needs were assessed.

There were safe recruitment policies and procedures were followed.

The service worked and developed links with local community groups and organisations.

Staff told us they felt supported by the management team and people spoke positively about staff.

We found four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Where regulations have been breached information about these breaches is at the back of the report. Where we have identified a breach of regulation which is more serious we will make sure action is taken. We will report on this when it is completed. Where providers are not meeting fundamental standards we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service.

When we propose to take enforcement action our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action taken.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This is the first time the service has been 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, 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. 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.

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.

Medication was administered kindly but we could not be assured it was always administered as prescribed.

The service's approach to risk management was inconsistent. Risk assessments were not always reviewed.

There were safe recruitment policies and procedures were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not fully compliant with the Mental Capacity Act 2005.

Meal choices were limited.

Staff were well trained and received regular supervision.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as caring. Our observations throughout the inspection supported this view.

Staff promoted people's privacy and dignity and treated them with respect.

People's end of life wishes were considered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always regularly reviewed and information was not always recorded appropriately to reflect people's current needs.

There was an activities programme but we observed people spending long periods of time without social stimulation.

Is the service well-led?

Inadequate

The service was not well-led.

Staff told us they felt supported by the management team, however we found the management oversight was not robust.

The systems for monitoring and checking the quality and safety of care and support provided were not effective.

The provider had not taken appropriate action to ensure the service was compliant with the regulations.

Rosehill House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was prompted in part by notification from the coroner about an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

This inspection took place on 12 and 17 December 2018 and was unannounced on both days. Two adult social care inspectors visited on each day.

We spoke with four people and three relatives visiting the home. We also spoke with the registered manager, the deputy manager, one senior care worker, two care workers, the activities co-ordinator and the cook. We looked at three care plans in detail and another nine care plans for specific pieces of information. We looked a medicine administration records. We also looked at various documents relating to the quality assurance and management of the home. We looked round the home, in people's bedrooms and in communal bathrooms, lounges and the dining area.

Before our inspection we reviewed all the information we held about the home, including previous inspection reports and notifications received by CQC. A notification is information about important events which the service is required by law to tell us about. We used this information to help us decide what areas to focus on during our inspection. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England.

Inadequate

Is the service safe?

Our findings

At the last inspection we rated this key question as requires improvement. We found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the provider had failed to ensure they notified us of 'other incidents', such as safeguarding concerns, which meant we were not aware of potential incidents of abuse that had occurred at the service. At this inspection we found this had not improved.

At the last inspection we also found medicines were not stored at appropriate temperatures and systems to calculate staffing levels were not robust. At this inspection we found improvements had been made to the system used to calculate people's dependency needs and staffing levels. The registered manager reviewed people's dependency monthly and allocated staff accordingly. However, whilst temperatures in the medicines room were recorded these were frequently slightly higher than the recommended temperature and action had not been taken to address this. At this inspection we found concerns relating to medicines administration, how risks to people were assessed and monitored, and infection control processes.

Staff rotas reflected the number of staff on shift and this was in line with people's dependency needs. The registered manager used a dependency tool to assess people's care and support needs. A relative told us "Yes, there's always staff." A staff member when asked whether there was enough staff said, "Yes…and the staff we have are experienced too."

People told us they felt safe living at the home. One person told us, "Oh, yes, it's a safe place to live." Another said, "They look after me well here, they do, yes." A relative said, "Yes, very safe living here, settled in nicely, good routine, good staff." A staff member said, "I'd be confident for my family members to come and live here."

Systems and process were in place to protect people from harm. Staff were trained in safeguarding and had their training refreshed every year. Staff were knowledgeable about safeguarding procedures and told us they were confident managers would act on concerns. A person told us, "If I was worried about anything, I'd talk to [name of manager] certainly." A relative told us, "Already spoken this week about a concern and sorted it out." Asked what they would do if they had concerns a staff member said, "I'd talk to the senior or to a manager and I'm sure they'd do something."

The registered manager monitored and investigated safeguarding referrals and provided these to the local authority for investigation, where appropriate, however we found these had not been reported to CQC. This constitutes a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Medicines were not administered safely and we could not be assured people received the right amount of their medicines. We checked the stock of five medicines (including two controlled drugs (CD)) and found the numbers did not tally with the numbers on the medicines administration records (MARs).

We could not be assured transdermal patches were applied correctly and in line with guidance. On day one

of our inspection no one had a body map for transdermal patches, which meant staff could not confidently track where patches had been applied. We discussed this with the registered manager and on day two people who had been prescribed transdermal patches had body maps in place.

Medicine administration records did not always correspond with the controlled drug register. We identified that a person had received a CD transdermal patch at 9am on the morning of 08/12/18 and had received another CD transdermal patch the same afternoon. Staff confirmed this person did not have two transdermal patches in place and explained that additional stock of the medicine had been received and they had mis-read the CD register and thought a patch was due to be replaced (the MAR did not show the application of the first patch). A senior carer said any of the care staff could counter-sign the CD register, however only senior carers administering medication received training.

We could not be assured staff applied topical creams to people as prescribed. Body maps were used for those people needing topical cream application, however topical creams were not applied regularly for two of the people we looked at despite their MARs saying the cream should be applied every day. A relative said, "They've not creamed [their] legs. They should be done twice a day."

Appropriate controls were not in place for people who were prescribed medicines on an 'as and when basis' (known as PRN) and guidelines for the administration of these were not followed. On day one we found PRN protocols, which would describe to staff how and when people should receive these medicines, were not in place. For example, we witnessed a senior carer giving someone paracetamol, which had been prescribed as a PRN, without asking or assessing whether the person was in pain. We asked the senior carer how they would know the person was in pain and was told this person always had paracetamol, and we saw from the MAR this was the case. This meant the medicine was not administered as prescribed. We discussed this with the registered manager, the deputy manager and a senior carer. On day two stock records were in place for PRN medicines but PRN protocols were not in place.

One person was prescribed Lorazepam for agitation 'as and when required' and was given Lorazepam every day. A senior carer was asked how they knew when to give this person Lorazepam and was told this was given to them every day. On day two a best interest decision had been recorded and this person had a 'PRN medication administration' care plan detailing to staff how to assess this person's mood and to record their reason for giving this person their medicine. A memo had also been issued to staff highlighting this change.

These findings constitute a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's care and support were not always managed or recorded in a consistent way. For example, on day one of our inspection we found people did not have personal emergency evacuation plans (PEEPs) in evidence. We brought this to the attention of the registered manager. On day two everyone living at the home had a PEEP; these were detailed and provided good information about the person, the support they needed and action to take in the event of an emergency evacuation.

People living at the home were placed at risk from controlled substances which are hazardous to health (COSHH). On day one we found the doors to the sluice room, cleaners' cupboard and hairdresser's room were all unlocked (locks were in situ and working): the doors to the sluice room and cleaners' cupboard were open. All these rooms contained COSHH substances. This was brought to the attention of the manager who said they should be locked. On day two the manager had purchased new 'code locks' and these had been fitted, we found all doors to these rooms were locked on day two.

Risk assessments did not always contain enough detail to ensure people were supported safely. Moving and handling risk assessments were not detailed and did not contain information about slings required to transfer: two people needed hoisting. For example, one person needed postural support from a specialist chair however this person's moving and handling risk assessments did not detail how this person should be supported to bathe, shower or toilet safely. This person's moving and handling care plan did not detail the type of sling to use when supporting them to transfer. We did not find a sling specifically for this person's use. We brought this to the attention of the registered manager. On day two appropriate slings had been purchased.

A choking risk assessment for one person was not clear and contained conflicting instructions. We witnessed this person being given different consistencies of food. When asked staff gave different information about how the type of food this person should receive. This person's care plan did not record the specialist advice given to the home to ensure the risk to this person from choking was minimised. We brought this to the attention of the registered manager. On day two the specialist speech and language therapists (SALT) had been contacted and correct information was available. A memo had also been given to all staff detailing the change and the cook was aware.

Care plans and risk assessments were not always regularly reviewed and relevant updates made to these. For example, a review showed a person was incontinent at night but their care plan had not been updated. Another person had fallen and whilst their mobility care plan had been updated to reflect their changing need their main care plan had not. Another person had not had their mental health / behaviour care plan updated since 15/09/17 however incidents had occurred since this date which would suggest people were at risk from this behaviour. Another person had fallen in May 2018 and twice in November 2018 but had not had their falls risk assessment updated since 19/03/18 and their mobility assessment updated since 27/10/18.

These findings constitute a breach of Regulation 12 (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control procedures were not being followed. On the first day there was a strong odour on the upper floor, bathrooms and toilets were dirty, and the hand gel dispenser was empty throughout the whole day. We observed a care worker transporting soiled bed linen on the bottom of a hoist used to transfer people. We observed dirty linen left in a corner of the upper floor corridor, this had not been placed in a laundry bag. We brought this to the attention of the registered manager. During the second day we found these concerns had improved, however at the end of the second day of inspection three rooms and one bathroom on the upper floor did not have soap.

People were at risk from infection. On day one we found one toileting sling was being shared between two people. Both people who needed hoisting did not have slings of slide sheets in their rooms and slings were being shared. Slings were kept at the bottom of the cupboard used for storing staff coats. This was brought to the attention of the registered manager. On day two the home had purchased more toileting slings, so these were no longer being shared. The two people who required person-specific slings had these in situ in their rooms and slings were no longer kept in the cupboard used to store staff members' coats.

These findings constitute a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed safe recruitment practices. A staff recruitment checklist was used. The process ensured employees were of good character and had the qualifications, skills and experience to support people using

the service. The home supported apprentices and evidence from the local college showed this support was good.

Records showed premises and equipment had been serviced regularly and appropriate checks made in line with guidance.

Lessons weren't always learnt from accidents and incidents. Monthly accident and incident monitoring took place which looked at the time and place of incident but did not consider specific details for individuals or what tasks people were attempting to do when falling. For example, one person had fallen on three occasions during one month, only once in their bedroom, but the interventions to reduced falls focussed on their bedroom environment.

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

Requires Improvement

Is the service effective?

Our findings

At the last inspection this key question was rated requires improvement. This is because we found improvements to the environment were needed to ensure people's individual needs were met by the design, adaptation and decoration of the service. For example, colour schemes of carpets, railings and light switches were not dementia friendly. At this inspection we found this had improved although some areas, such as light switches, needed further improvement. Dementia-friendly signage was in place and colours were suitable to provide an appropriate environment for people living with dementia. A person told us, "I've been able to bring in my chair from home."

At the last inspection we also found care records did not always record where a person lacked capacity to consent to their care and treatment. At this inspection we found this was still the case. For example, there was no evidence people, or their relatives, were involved in care planning. None of the care plans we looked at contained evidence of any involvement of people or relatives in their care plans or their care. Only two of the care plans we looked contained a consent form for care and support. The review of one person's care plan showed 'Acted in best interest of [name of person]' and had been signed by a senior carer. There was no record of the best interest decision. The other consent form we saw was blank.

We witnessed one person who was having their nails painted. A visitor for this person commented, "She's going out for a meal tomorrow, she's not right happy having her nails done." We were unsure whether this person had consented to this activity and staff and records did not give any indication.

One person had 'close observations' recorded for two days (although there were no dates recorded of when this took place), it was not recorded why this had taken place or whether they had consented to this. The manager explained everyone was placed on close observation for two days following initial admission, however there was no evidence this was explained at pre-assessment nor was this recorded.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met and found it was not fully compliant.

Mental capacity assessments and best interest assessments had taken place for some aspects of people's

lives however for one person who was receiving medication on an 'as and when' basis it had not been considered whether it was in their best interest. We discussed this with the registered manager. On day two there was clear guidance for staff about administering this person's medication in their best interest and staff were knowledgeable about this.

We found another person who lacked capacity to consent had bed rails in place however there had not been a best interest decision recorded about their use.

The provider had submitted applications to a supervisory body for authority to deprive someone of their liberty and had trained staff in understanding the requirements of the Mental Capacity Act in general and the specific requirements of the DoLS. A staff member explained, "Some people have more capacity here than they do at home, because we can support them, explain the question and help them think through their answer. We can help them make choices, like what to wear, if they can't tell us we can show them what is in their wardrobe and look for them to pick something out."

These findings constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they received regular supervisions and appraisals, however records showed none of the staff had received an appraisal in 2018. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important to ensure staff are supported in their role. At a previous inspection in 2016 we found this was also the case. Records did show staff had received supervision at regular intervals. At these meetings staff were able to discuss areas for improvement, concerns and training needs. A staff member said, "Supervision and appraisal in place, [I] can't remember how frequently or when the last one was."

People we spoke with told us they thought staff were well trained and performed their jobs well. The staff training matrix showed staff were provided with relevant training and refresher training to update their skills. Staff told us they received an induction. A staff member said, "We have good training, everything we need and if we want anything special we only have to ask." Another staff member when asked about training said, "Plenty…they're supporting me to learn what I need to do." A training plan was in place to ensure staff had access to training when they needed it.

A relative told us, "Yes, staff are well trained, grandma has Alzheimer's, understand her needs, she chats to the manager quite a lot, grandma calls him doctor." Another relative said, "The staff have all the skills they need, they must have, it's the only place [name of person] will settle, and [they're] complex."

People were positive about the meals offered. People's comments included, "I'm a bit funny with my food, [name of manager] sat down here with a notepad…and wrote down what I like to eat and…and bought it all for me".

There was only one main meal on offer at each meal time, although we witnessed alternatives being offered if people did not want to eat this, this meant they had to wait until it was made and brought to them. Some people chose to eat in the rooms or communal lounges we saw this was accommodate and meals take to people covered. We asked two people who chose to stay in their rooms what they were having to eat and were told, "no idea what [I'm] having for dinner". We asked one person whether they get a choice and was told, "More or less, they'll do something different if I want it."

A person's dislike of mash and meat was recorded on their review records but not on their care plan. All the

staff we spoke with were aware of this person's meal preferences but an alternative meal was not prepared; staff and the registered manager told us this person could have 'whatever they wanted'. On both days this person chose to have crumpets for lunch.

Staff were knowledgeable about people's preferences but there was little evidence this was recorded. A relative told us, "Staff here understand [name of person] well, they are great." A staff member said, "Getting to know what each person likes; their family, their interests and hobbies. Talking about families, hotels they've stayed in, sharing photos."

People were supported to eat and drink. Staff encouraged people to eat. We observed one person who kept leaving the table but staff gently encouraged them back to the table and to eat. Staff supported people to eat who were unable to do so themselves. This was done with dignity, staff made eye contact and asked whether they needed support, staff chatted throughout. The cook was knowledgeable about people's likes and dislikes and had received information from staff about people's dietary needs and allergies, which was met.

Regular drinks and snacks were offered throughout the day, although people were not able to serve themselves. Staff were, however, vigilant, for example, one person had been for a walk and when staff saw them come back into the home they immediately offered them a hot drink.

We found people were weighed regularly and weights were monitored. Where people had lost weight timely advice and intervention had been sought from health professionals. Where people were at risk of malnutrition their food intake was recorded and monitored. We looked at fluid charts and saw the fluids people consumed were recorded, although these sheets were missing totals. We discussed with the registered manager about the home calculating fluid targets for people based on guidance from the National Institute for Health and Care Excellence (NICE).

The service had good plans in place to ensure staff were organised to deliver effective care and support. Detailed handovers took place between senior care staff and staffing rotas were planned so there was an overlap of staff to support information sharing and manage workloads. Information sharing with relatives was good. A relative said, "We are informed of anything and everything that changes," and, "They get things done here. The manager does well, getting them all working together."

People had appropriate and timely access to healthcare professionals. A person told us, "It got me worried about the pains in my legs, so they've called the doctor for me." Care plans reflected health professional visits and advice, for example, documentation was held about people's spectacles and hearing aids.

Good

Is the service caring?

Our findings

At the last inspection this key question was rated good. We found this to be the case at this inspection.

All people and relatives we spoke with told us staff were kind and caring. People's comments included, "Care staff say '[person's name] do you want us to help you?'", "Can't grumble at all, you can always tell the ones who love their job", "A new one came not long since [they've] helped me a lot", "Made to feel very welcome, all the carers are lovely", and "That young lady's good, brings me shopping and sometimes does my nails". A relative told us, "Staff really friendly, always talk, have a good chat, kept updated, really good." Another said, "The carers are very caring."

Staff comments included, "We care for each person as though they are our own relatives", "I love the residents here and involving everyone, making it feel like a family", and, "[I'm] proud to be a friend and confidant to the residents, one person stays in their room and tells me lots of things about [them]self and their family, even things they can't tell [their] family".

We observed positive and friendly interactions between staff and people. We observed one staff member acting with care and patience when moving someone from their wheelchair to a chair using a zimmer frame. The staff member gently encouraged the person to take their time, explained each stage, and used touch to support and guide them.

Staff treated people with respect and dignity. We saw staff knocking on people's bedroom doors and waiting before entering. A staff member said, "I shut the door before doing any personal care, never do anything that would make people uncomfortable." On day one of the inspection we observed a person's 'daily accountability record' left opened and unattended in a communal lounge for over 30 minutes however after discussions with staff we were satisfied this was an oversight and isolated incident.

People's needs in relation to the protected characteristic under the Equalities Act 2010 were considered. The registered manager told us, and we saw from records, this was checked at the point of pre-admission. We saw people's communication needs were checked and recorded, which meets the requirement of the Accessible Information Standard, and staff met these, for example, maintaining eye contact for someone who had difficulty hearing. The registered manager told us information about the home was available in different formats to meet people's individual communication needs.

Whilst we did not see involvement of either people or relatives in the formal planning and review of people's care as this information was not documented appropriately we did find that people's individual personal preferences were understood and met by staff. For example, we observed staff administering medicines waiting until one person had eaten their breakfast before asking them if they wanted their medicine because they knew this was the person's preferred time to take their tablets. Another person was given their tablets on a spoon because staff knew this was how they liked to take them. On person's relative liked to eat their evening meal in the lounge with their relative and staff accommodated this, treating the relative compassion and kindness.

Some people in the home used an advocacy service and were encouraged and supported to do so. The registered manager and staff encouraged the use of the service and information about this was displayed in the home.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated this key question as requires improvement. This was because information about people's preferences and life-history lacked detail. At this inspection we found this continued to be the case. For example, one person's pre-admission and assessment document was blank under the heading 'recreational and spiritual activities'. Another person's pre-admission and dependency assessment was blank under the headings 'current interests' and 'who do you see'. Both these records were blank under the heading 'can the Home meet these identified needs?' and had not been signed or dated.

We observed people being offered a choice and people we spoke with confirmed their wishes were respected. The registered manager explained how they assessed people's needs prior to the admission to the home. The pre-admission assessments we looked at did not always gather information about people's preferences. We also found the care plans were not detailed enough to meet the needs and preferences of people. For example, in one person's sleep plan was limited to recording their retiring and rising times. Despite reviews showing this person was unsettled at night their care plan did not record their preferences of bedding, pillows, lighting or routine all of which may have helped to support this person.

Another one person's dislike of 'mash' and meat was identified at a review but their care plan had not been updated to reflect this.

We found one person who had been admitted to the home for respite which had quickly become permanent had care provided using a basic short-term respite care plan rather than a full care plan. We discussed this with the registered manager and was told it can take six to eight weeks before someone has a permanent care plan produced. This means people's needs and preferences may not be met.

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

At the last inspection we shared with the registered manager the negative feedback people had given about the quality and range of activities offered. At this inspection people were positive about activities. For example, one person told us, "That young lady is good, brings me shopping and sometimes does my nails. She's ever so good." Another said, "School came to sing, I did enjoy it."

People received activities which met their social needs. There was an activities co-ordinator who provided group and individual activities and there was an activities programme displayed on the noticeboard. On day two of our inspection this included a visiting choir from the local primary school we sang carols and a Christmas card exchange. People had a recreational diary, which detailed whether an offered activity was accepted and if the person had enjoyed it. Plans were in place to develop a profile sheet for each person detailing the types of things they enjoyed. We observed, however, people did not always receive interaction if they were seated in a different communal lounge, or in their bedrooms. Some people had limited activities recorded with many people's records showing, for example, lots of manicures with little evidence this would have been a person's preference. One person told us they had "stacks of books with photos in to sort out"

but no evidence this person had been supported to do this.

The registered manager was knowledgeable about equality and diversity and described how they supported people who may be at risk by having a protected characteristic.

People told us they felt supported by staff who knew them and relatives we spoke with confirmed this. They also felt able to feedback on care they received and were happy with how concerns and complaints were dealt with. Two complaints had been received in 2018; these had been dealt with in line with provider policies. People found the complaints process easy to use. People were happy with the way their complaint was handled. People were satisfied with the outcome. The manager was open and inviting to people who had complained.

There was no one receiving end of life care during our inspection visits. We found some people's care plans recorded their end of life wishes and it was clear where people had a DNACPR (do not resuscitate plan) in place. The registered manager told us the home had previously supported people at end of life and staff had been trained in this area.

Inadequate

Is the service well-led?

Our findings

At the last inspection we rated this key question as requires improvement. This was because the service registered manager did not always submit notifications to the Care Quality Commission every time a significant incident had taken place and found there was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found this continued to be the case. For example, the registered manager had recorded six safeguarding concerns and these had been notified to other agencies, as required, however these had not been notified to CQC. In some instances, the registered manager had failed to notify CQC of a significant incident, such as a serious injury, and we could not be certain CQC had been notified of all the deaths which had occurred in the home. We discussed this with the registered manager and was told "[I] thought it [notifications to the Care Quality Commission] was for police incidents only".

This constitutes a continuous breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found poor management and no evidence of provider oversight. There was no evidence of improvement in this key question since the last inspection.

Audits, with the exception of those for accident monitoring, medicines administration and staff file audits, were not regularly undertaken. Audits that had taken place had not always picked up on the issues found during the inspection or were not robustly monitored. For example, monthly medicines audits took place but had not identified the issues we found and we could not be assured these were robust. These audits included a random stock count of medicines, however during our inspection four out of five random counts undertaken showed discrepancies in the amount of medicines against the records. These audits had not identified the risks to people because of the increased temperatures in the medicines room. Medicine audits had not identified the lack of recording for PRN protocols, body maps and dates of opening on packaged medicines despite these being part of national guidelines.

Although regular checks were undertaken by the handyman there was no evidence these were checked or audited by managers. Cleaning records were completed but there was no evidence these were checked or audited by managers. Kitchen records showed a regular cleaning schedule and food temperature checks but there was no evidence these were checked or audited by managers.

Procedures to ensure the premises were clean and safe were not apparent. The registered manager told us they undertook a regular 'walkround' of the home however there was no documentary evidence of this and during our inspection we found areas of the home in need of urgent cleaning and refurbishment, for example, a hole in the floor and peeling floor covering in shower rooms which had not been previously identified.

Recording and analysis of accidents and incidents was basic but did take place monthly. For example, whilst the manager recorded numbers of falls and the time the analysis did not show where the fall took place,

staffing levels, or what the person was doing.

There was little evidence of ensuring knowledge was updated in line with national guidance. For example, neither the registered manager, deputy manager nor the two senior carers we spoke with showed an understanding of PRN protocols. Following a discussion PRN stock control sheets had been put in place for people prescribed PRN but there were still no PRN protocols at the end of day two of our visit.

The registered manager had failed to ensure staff received regular appraisals. There had not been any staff appraisals undertaken within the last 12 months.

These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager in post at the time of the inspection. People, relatives and staff spoke positively about the management of the home. A person told us, "[Name of manager] is marvellous, a real angel." The registered manager described how they had regular contact with the provider, telling us the provider visits the home twice per week and is "always at the end of a phone". When asked about the support from the provider the registered manager said, "Anything we need really, approved a lot of the work, quite approachable, staff know they can contact them," and staff confirmed this. The registered manager had an open door policy and people, relatives and staff told us the manager was approachable and responsive.

Staff were asked for their feedback through meetings and surveys. Staff were positive about the home, one staff member said, "I like my job here and enjoy what I do." Another staff member said, "[I] love working here." The home also undertook regular surveys with people and relatives and analysed and reported on findings. Recent surveys indicated people and relatives thought the service was good. It was not clear how this information was used to improve the service.

The registered manager explained plans to introduce an electronic care planning and recording system which was scheduled to take place within the following five weeks and a sister-home manager demonstrated this to two of the inspectors. The home planned to run a dual system of paper and electronic records to ensure a back-up system until fully operational. The registered manager told us their vision was for "good to be second nature" and for the home "to be as risk proof as we can".

The home had developed links and good-working relationships with three local GP surgeries and communication and working practices were good. To improve community and social links the home arranged and encouraged visits with the local primary school (who attended to sing carols during day two of our inspection), the local Mencap organisation and local dementia friends.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care No evidence of involvement of people or relatives in care planning. Best interest decision weren't specific to the person or activity. Details about people's social history or preferences were not recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always asked or recorded.