Orchard Care (South West) Limited

Restgarth

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 29 and 30 July 2015 and was unannounced. We last inspected the service on the 7 July 2014 and found no concerns.

Restgarth provides residential care without nursing to up to 30 older people. People living with dementia may be living at the service. On the days we inspected 26 people were living at the service but one person was in hospital. Nursing care is provided by the community nursing team.

A registered manager was not in post at the time of the inspection as required as part of the service's registration with the Care Quality Commission (CQC). 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 service had been without a registered manager since May 2015. Staff were in charge to manage the service. There was one manager in charge with two staff supporting from the provider's other service. All three staff supported the inspection. However, they lacked any historical information having been at the service for a short period of time.

We inspected Restgarth due to receiving information of concern that people's needs were not being met. For example, people were not having their continence needs met, people were not having regular baths and shower,

Summary of findings

people living with dementia were not having adequate nutrition and medicines were not administered as prescribed. We reviewed these concerns throughout the inspection.

There was not sufficient staff to meet people's needs safely on the first day of the inspection. We requested the staff in charge took immediate action in respect of this. They completed an assessment of how people were dependent on staff (called a 'dependency assessment') and identified more staff were required. A representative of the provider attended the home each week and checked the quality of the service took place. When concerns about the service were received in July 2015 the provider acted and systems were put in place to identify and address a number of concerns. Staff numbers were found to be an issue but immediate action was not taken to address this while new staff were recruited.

Staff were employed from an agency to meet people's needs and the requirements of the dependency assessment on the first day. On the second day we observed increased numbers of staffing was maintained. The provider gave an assurance the number of staff in the future would be in line with people's needs.

People were not protected by staff who could identify abuse or knew what action to taken. Staff had not known how to share their concerns with agencies outside the service. People were placed at risk of inappropriate care as a result.

Staff were recruited safely. However, people were not looked after by staff, who were suitably trained, supervised, appraised or were having their competency checked on a regular basis. Staff had not undertaken sufficient training to enable them to understand and support the range of people's needs. This was noticeable in relation to looking after people living with dementia. People living with dementia were not having their nutritional or social needs met. Other people's nutritional needs were met and people contributed ideas for the menu. People could choose alternative meals to those available at each meal.

During the first day of inspection it was very difficult to assess whether people were treated kindly by staff as they were rarely visible. When we saw staff and people together we were heard staff speaking both kindly with and impatiently to people. They greeted people warmly and respectfully. However, staff did not have time to spend with people as they were rushed in carrying out their tasks. On the second day with more staff, staff and people were observed to be comfortable in each other's company. There was a greater presence of people moving around the service and laughter between people and staff. People said their dignity was always respected and with more staff felt staff were less rushed.

People had risk assessments in place and care plans. However, these were not personalised and did not identify all the risk or needs of people who were living at the service. There was no evidence they had been written with people or their representatives. This has been identified in a recent audit carried out by a representative of the provider and was being addressed.

We had some queries about fire safety which we passed to the fire service, who have visited and are satisfied with the fire safety arrangements.

People could see their GP or other health professionals as required. However, people were not having their continence needs met but this was addressed before the inspection was completed. That is, the district nurse service was supporting staff to complete new assessments and supporting staff to manage people's continence needs. Staff told us more staff meant they could prioritise supporting people to go to the toilet. Staff were supporting people to ensure they did not develop skin ulcers. The district nurse service were now supporting staff in relation to continence care as well as maintaining people's skin integrity. Plans were in place to support people's end of life.

People had their complaints investigated however, there was not sufficient evidence that the learning from people's or relatives concerns resulted in changes to the service to reduce the likelihood of it occurring again. The main issue was in relation to people's laundry and items of clothing being lost or taking a long time to come back. The issue with the laundry was raised with the service from December 2014 to July 2015 with no evidence this was resolved to people's satisfaction.

People were not supported to follow their interests or prevent them becoming socially isolated. People were largely living isolated lives in their rooms and rarely generating friendships or companionship with other people in the service. We were unable to judge how much

Summary of findings

this was about choice and how much had become part of the staffing issue at the service. Group activities were offered most weeks. People could attend a religious service each month. Staff told us they did not have time to offer that one-to-one care and time. They hoped this would be possibly with the increased staff numbers. We have recommended the provider review the latest guidance on providing activities for people living in care homes.

Staff were not following a kitchen cleaning schedule and the kitchen was observed to be dirty. This was referred to the local authority food hygiene service. The food hygiene inspector has visited and found the service's food hygiene practice to be safe. In all other respects, staff were following safe infection control procedures.

Staff in charge understood their responsibilities in relation to assessing people's mental capacity and not depriving people of their liberty illegally. Staff asked people's consent before providing care and support. People had their medicines administered safely.

Staff in charge had identified that audits of aspects of running the service needed to be improved. For example, audits of medicines, care plans, infection control, and falls had been intermittent. Systems were being developed to ensure these were more frequent. People had not been asked about staffing and whether they were concerned about this. We requested therefore the staff in charge asked people about their view of the numbers of staff. People responded that their needs had been met better with more staff. There were systems in place to check the building and equipment were checked and action taken when required.

CQC records showed we had not received any serious injury notifications for 2014 and 2015 to the date of the inspection. However the provider has advised there were no notifiable injuries that took place during this time.

We found 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 the 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. There was insufficient staff to meet people's needs safely. Action was taken to improve this by the end of the first day of inspection.

People were not safe as staff did not understand how to identify abuse and report concerns. Outside agencies had not been contacted so concerns staff had could be investigated.

Risk assessments were in place to reduce the likelihood of people coming to harm however these were not personalised or comprehensive. This had been recognised by staff in charge and steps put in place to put this right.

We had some queries about fire safety which we passed to the fire service, who have visited and are satisfied with the fire safety arrangements.

The kitchen was seen to be dirty which was passed onto the local authority food hygiene service to review. The food hygiene inspector has visited and found the service's food hygiene practice to be safe. In other aspects, people were protected from the risk of infection as the service had effective infection control policies in place that were followed by the staff.

Staff were recruited safely.

People's medicines were administered safely.

Is the service effective?

Requires improvement

The service was not always effective. Staff were not suitably trained and supported to ensure they could meet people's needs effectively.

People were not all having their nutritional needs met.

Staff were observed seeking people's consent before they commenced care. Staff in charge ensured people were assessed in line with the Mental Capacity Act 2005 as required.

People could see their GP and other health professionals as required.

Is the service caring?

Requires improvement

The service was not always caring. When there were enough staff, they were caring towards people but rather impatient when they were busy.

People said staff did not have time to listen to them or ensure they were in control of their care. People felt this improved when there was more staff.

People and a visitor spoke well of the staff. People stated they had their dignity respected.

Summary of findings

People had end of life plans in place to support them to end their life in line with their choices.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans were not personalised, written with them or reflective of people's needs. Staff said they were unable to respond to people's needs fully due to their having to prioritise needs.

People's continence needs were not being appropriately managed. Action was taken to address this before the inspection ended. People's skin needs were carefully managed to prevent them from developing skin ulcers.

People were not supported to follow their interests or prevent them becoming socially isolated.

The service had a complaints policy in place. Not all of people's concerns were acted on or investigated. There was no evidence that complaints were used to make continuous improvements.

Is the service well-led?

Requires improvement

The service was not always well-led. There was not currently a registered manager in place. A manager was in post and they were being supported by staff from the provider's other service.

CQC records showed we had not received any serious injury notifications for 2014 and 2015 to the date of the inspection. However the provider has advised there were no notifiable injuries that took place during this time.

Audits of various aspects of the service by the manager had not been consistent but this was being addressed. Audits had not identified all the concerns raised during the inspection.

The provider visited regularly to review the quality of care being provided in the service. The provider took action when concerns were raised.

People and families were asked their view of the service. Systems were in place to check on the maintenance of the building and equipment.

Restgarth

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 took place on the 29 and 30 July 2015 and was unannounced

On the first day of the inspection four inspectors carried out the inspection. On the second day one inspector attended the service.

Prior to the inspection, we reviewed the information held by CQC. This included previous inspection reports and notifications we had been sent. Notifications are details of specific events registered people are required to tell CQC about.

During the inspection we spoke with six people and one visitor. We reviewed the care records of nine people in detail to check they were receiving their care as planned. We observed how staff related to people in the dining room, corridors and lounges. We sat with people at lunch on both days and spoke with them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 staff. We read three staff personnel records and the training records for all staff. We also reviewed other records held by the service to support the running of the service. This included policies, procedures, audits and records of how the provider ensured the quality of the service. We spoke with one member of the district nursing service during the inspection.

Requires improvement

Is the service safe?

Our findings

There was insufficient staff to meet people's needs safely. On the first day of the inspection people and staff told us there was not enough staff. Staff told us they had raised concerns with management about not having enough staff for some time. Staff all confirmed the current staffing levels had not been adequate for them to meet people's needs fully. For example, managing people's continence needs and providing baths or showers as frequently as people wished to have them. In the morning, we observed staff were rushing around to meet one person's needs then another. Staff were not available to meet people's needs in the lounges. One staff member was serving breakfast and dealing with laundry at the same time. At lunchtime people's meals were taking a long time to serve with one staff member trying to serve lunches and support people living with dementia to have their needs met in the dining room. Staff rotas also showed there were not enough staff with fewer staff on some days than was observed to be on duty during the inspection. We spoke with the staff in charge and asked how they were ensuring they had enough staff to meet people's needs safely. Staff in charge were not using any method to ensure they had the correct number of staff required to meet people's needs.

A representative of the provider advised they were aware there were not enough staff and had sought to employ more staff who were waiting for the necessary checks to be completed. However, they had not acted to use alternative ways to ensure they had enough staff while they were seeking to recruit more staff.

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

We requested the staff in charge take immediate action so they could evidence they had enough staff to meet people's needs safely. They completed a dependency assessment and identified they required significantly more staff. Immediate action was then taken to ensure there were enough staff that afternoon and on the second day of the inspection, in line with the dependency assessment, to meet people's needs safely. The provider gave assurances that these staffing levels would be maintained.

People were not protected by staff who understood how to safeguard them from the possibility of abuse. Staff we spoke with had not received training in safeguarding. Staff did not understand how to identify abuse or act if they were concerned about someone in their care. Staff also did not understand how to whistle blow in the event of having concerns about how people were being treated. Staff did not understand the role of the local authority or CQC in respect of both safeguarding and whistleblowing.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had policies to address both safeguarding and whistleblowing. The safeguarding policy contained the following contacts: Cornwall Council Adult Social Care & their emergency out of hour's team, Care Quality Commission and the Owner/Director's personal number if in need of contact. The whistleblowing policy however, did not contain the necessary contact details for staff to use should this be required. The provider has stated this has been updated.

People did not have all the risk assessments in place to assess their likelihood of coming to harm while living at the service. People had risk assessments in place to measure the risk of developing pressure ulcers, while being supported to transfer, and falls. However, all risk assessments were generic and contained the same information for each person. No risk assessments contained details of how the individual was involved in assessing and managing their own risks. People did not have their risk of malnutrition assessed despite the records showing this was a potential risk for some people. The lack of personalised risk assessments and MUST (Malnutrition Universal Screening Tool) had been identified in a recent internal quality audit and action was being taken to review all risk assessments for each person.

The service had internal and external risk assessments in place to ensure they monitored the property. There were individual personal evacuation plans in place for each person in the event of an emergency, such as fire. The service also had a contingency plan in place to deal with emergency situations such as fire, flood and poor weather. However, the plan lacked up to date contact details of some essential contacts such as the local authority and utility companies. A place of safety had been identified locally where people could be relocated in the event of an issue arising. We had some queries about fire safety which we passed to the fire service, who have visited and are satisfied with the fire safety arrangements.

Requires improvement

Is the service safe?

The service had effective infection control policies in place. The service presented as clean and odour free except for two people's rooms which smelt strongly of urine. We discussed this with the staff in charge and were advised they had ordered special cleaning solutions in order to address the smell in these rooms. We raised a concern about staff handling food and laundry at the same time which was stopped immediately. We were concerned about the cleanliness of the kitchen and food storage areas which we have referred to the local authority food hygiene team. We were informed immediately following the inspection that there had been a thorough clean of the kitchen and food storage areas. The food hygiene inspector has visited and found the service's food hygiene practice to be safe. Staff were provided with hand washing facilities, aprons and gloves. There were appropriate contracts in place to ensure clinical waste was removed safely.

Staff employed by the service were recruited safely. New staff did not start to work at the service until all the necessary checks were in place. Applicants completed a detailed application form/process and attended a formal interview. All staff underwent a probationary period to ensure their on-going suitability for the role they had been employed for.

People's medicines were administered safely. We found there was not always a person trained in the safe administration of medicines on shift overnight. This meant people had to wait for their 'as required' medicine such as pain relief until a suitably qualified staff member could travel to the service. Before the inspection was completed staff in charge ensured there was a staff member qualified in administering medicines on each shift 24 hours a day. Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff confirmed they understood the importance of safe administration and management of medicines. Medicines Administration Records (MAR) were all in place and had been correctly completed. Medicines were locked away as appropriate. Body charts were used to indicate the precise area creams should be placed and contained information to inform staff of the frequency at which they should be applied. There was an issue in respect of staff not dating all prescribed creams but this was address on inspection. The staff in charge told us that all prescribed creams were replaced monthly to ensure they remained in date.

Requires improvement

Is the service effective?

Our findings

We reviewed the training records for staff and saw there were several gaps in this record. Of the mandatory subjects as identified by the provider significant numbers of staff had not received up to date training in areas such as safeguarding adults, infection control, moving and handling, promoting dignity and compassion, diet and nutrition and record keeping. Not all staff had completed training in fire safety and first aid. All staff had recently completed a food hygiene course.

Staff told us training had not always been updated or reviewed. Staff were not always trained in areas to meet people's specific needs. Records showed no staff had training in dying and bereavement and caring for people with diabetes. This is despite people in the service having a diagnosis of diabetes. Very few staff had been trained in how to care for people living with dementia. All staff we spoke with told us they had not received any training in meeting the needs of people living with dementia. Two staff told us they did not understand the needs of people living with dementia and would like to know more so they could support them fully. This was despite several people living at the service who had short term memory loss or were living with dementia. We also observed staff were impatient with people living with dementia. Also, in discussion with us did not understand the needs of the people with dementia they were caring for.

Staff were not adequately supported to carry out their role effectively. Some staff said they had supervision rarely and others not all. No staff had a recent appraisal or were having their competency checked to ensure they were able to continue to carry out their role effectively. Staff administering medicines were not having their competency checked regularly in order to confirm they continued to do this appropriately.

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

People were not always having their nutritional needs met. People living with dementia were not having their nutritional needs met or identified as a concern. Due to insufficient staff on the first day and staff being unsure of their role on the second day, people who needed staff encouragement to eat, drink and engage with their meal were not taking on sufficient nutrition. For example, on both days we saw two different people get up and leave the dining table on several occasions without eating their meal. They were told repeatedly by staff to "sit down". No other main meal food options were offered and staff did not positively encourage people to eat. Desserts were offered but these were left or partially eaten. When we checked with staff in charge it had not been reported these people had not eaten or drank much. Staff in charge confirmed these people's nutritional intake was not known or being monitored or referrals made to other services.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person cared for mainly in bed had been assessed by the speech and language service to ensure they received their food so they could swallow safely. This was prepared and given as planned. Also, staff were keeping a careful record to monitor they were consuming enough food and fluid. Staff provided their support as required. People had food supplements as required.

People gave both positive and negative comments about the food. Most enjoyed the meals but we also heard from people that they felt it could be "predictable" and a bit "bland" at times. People were happy with the portion sizes and could have more if they liked. People were asked their preferences and could choose alternatives. The chef was keen to ensure people could have their choices met. For example, people on a special diet were offered imaginative alternatives if time allowed it.

At lunch on the first day people had to wait for each course for a long period of time. This improved on the second day with more staff but staff were unsure of their role. Staff told us they did not feel they had "permission" to sit with people in the dining room who required support. All staff supported the chef by serving meals and desserts. This took them away from supporting people in the dining room or people's own rooms. We discussed this with the staff in charge who said they would look at lunchtimes to ensure staff were organised and better able to meet people's needs.

We observed staff always sought people's consent to care before delivering any service to people.

Staff in charge understood the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Other staff were unsure what actions they would take if they felt people were being

Requires improvement

Is the service effective?

unlawfully deprived of their freedom to keep them safe. For example, preventing a person from leaving the home to maintain their safety. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. We found people had their capacity assessed and best interests were recorded.

We were advised by staff in charge that only one person required a DoLS at the moment and we saw this record was current and had been approved by the appropriate authority. There were a number of other DoLS in place but most of these had passed their review date. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Staff in charge were unsure whether these DoLS needed reviewing but advised us they would review them as soon as possible to ensure people were not being deprived of their liberty illegally. The provider has since qualified: "The other residents that require a DoLS have had their urgent and standard authorisations sent to the appropriate person at the local authority and are still waiting to be authorised".

People told us they could see their GP as required. Other medical appointments were also offered. For example, people could see a podiatrist, dentist and optician. The district nurse service felt the service asked advice in a timely and appropriate way. Records did not always detail people's medical needs and how these had been met by their GP, district nurse or other health professional attending the service. We discussed this with the staff in charge who told this was being reviewed. New forms had been developed to ensure this information was recorded accurately.

Requires improvement

Is the service caring?

Our findings

During the first day of inspection it was difficult to assess whether people were treated kindly by staff as both staff and people were rarely visible. However, on the rare occasions we saw staff and people together we heard staff speaking both kindly with and impatiently to people. They greeted people warmly and respectfully. However, they did not have time to spend with people as they were rushed in carrying out their tasks. At this point some staff presented as less friendly and caring.

Staff did not have time to listen to people's needs and ensure they were in control of their care. For example, one person told us: "There are not enough on duty throughout the day; the staff are lovely but always very busy" adding there was nobody they could talk with sometimes, as there were no staff in the lounge or dining room.

During the first morning two people sat in one of the lounges. One read a newspaper; the other dozed off. Elsewhere the lounges were empty. People we spoke with over lunch said they were happy with staff and how they treated them. We observed little staff interaction during lunchtime and little of note that showed people's needs were being met emotionally. For example, one person waiting for their lunch dozed off. Other people just sat in silence.

On the second day with more staff, the atmosphere in the service was different. Staff and people were observed to be comfortable in each other's company. There was a greater presence of people moving around the service and laughter between people and staff. People told us, "I'm having my feet and legs washed daily", "I'm having a shower every morning" and, "The staff seem more relaxed and are not rushing around".

Staff spoke passionately about the people they were caring for. Staff said this was the first for a long time they had been able to offer emotional support and time to people. One staff member told us: "Today is calmer; lots of staff means we have been able to meet lots of people's needs and give that extra touch which was missing" and another, "I did not have time to give that one to one quality time before today".

Another staff member told us: "Residents come first. I look on them as family. Their families have trusted us to look after them" but added they feel they have let the families down because they have not been able to provide the level of care they wanted. A fourth member of staff told us: "We have had to prioritise need when the call bell rings. People had to wait. Today we have been able to meet people's needs quickly".

People mainly stayed in their rooms. We were unable to judge how much this was about choice and how much had become part of the staffing issue at the service. There had been an issue for some time of people walking into other people's rooms without permission. The provider had attempted to address this by putting coded locks on people's doors. However it was still being raised as a concern by some people and family that people were still walking into rooms uninvited. From this a negative atmosphere between people who lived in the service had developed. Staff explained they had not had the training or time to address this.

People commented staff respected their privacy and dignity was respected.

Families visiting people on the day of our inspection were positive about how staff spoke with them and treated them. They were welcomed and felt the staff were kind and considerate. A family member had written in response for feedback on the service: "I have always felt supported personally which helps me understand my relative better when I visit".

People had their end of life choices assessed and discussed with them. Most people had their choices recorded on their care files. People's family were also involved as required.

Requires improvement

Is the service responsive?

Our findings

The provider had a complaints policy in place. The complaints policy was made available for people and family members. Complaints in relation to the concerns raised prior to the inspection had been investigated. Other concerns were investigated. However, there was continual mention in questionnaires of concerns about the way people's laundry was being looked after by staff. Concerns were about the length of time it took for clothing took be returned and items going missing. One family member had complained in December 2014 about this issue. Another family member had also raised a similar concern later in 2015 about their relative's clothes not being ironed or returned in a manner that ensured their relative was nicely dressed. There was no evidence of learning from this to ensure people's issues about the laundry had been resolved for the benefit of everyone. Staff advised they had struggled to deal with people's laundry along with the other tasks demanded of them.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of inspection we were told by staff that the laundry had been completed as it should be. Staff in charge told us they were seeking to resolve the issue with people's laundry with how the laundry was run being under review.

People had care plans in place however, these were not personalised and did not reflect people's current needs. Staff did not have individual guidance on how to support people and the majority of information in people's records was the same for each person. For example, the information about each person living with dementia was the same. There was no information about how dementia affected the individual person or how staff were required to support that person. Some records had other people's names in them. Records also contained incorrect information. For example, one person's assessment on coming to live in the service said they did not like their nails painted under their 'dislikes'. In a section written at a later date on 'tasks staff could undertake' it stated staff should offer hand therapy and paint their nails. This person could no longer communicate their wishes and therefore would be unable to say whether their original view had changed or not.

There was no evidence of involvement with the person or their representative in respect of their care plans. Daily reports were repetitive and did not relate to people's care plans or how people's needs had been met. One family member told us they had been fully involved in the care planning process but had not seen the final version of the care plan. They reviewed the care plan with us and noted an error around their relative's continence care which did not detail this person had a catheter fitted or how staff were to manage this need.

At our previous inspection in July 2014 we had highlighted the provider might like to review how they managed people's information. This was because people's information was stored in separate files in different locations. We found the same situation remained. When we asked for all the information on people we were reviewing, we had to ask more than once if we had all the information held. Staff were unsure where all the information was. Staff told us they did not read the care plans but relied on staff handovers and the communication book to ensure they had the necessary information.

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

We discussed the recording of people's care and their involvement with planning their care with the staff in charge. We were told an audit in July 2015 had identified the care records were not up to standard and were in the process of being rewritten. A new system was being introduced. However, these had yet to be written. Staff had been given the role of key worker for two people each and were currently being trained to complete the paperwork properly. They would then work alongside people and their family to gather the necessary information. All records of people's care would then be collated in one file.

People's continence care needs were not being managed well. We spoke to the district nurse and found two people who staff told us they were struggling to meet this need had not been referred for a continence assessment. We observed in the first morning of the inspection another person who wore continence pads was not offered the opportunity to manage their continence needs by going to the toilet. Staff told us they had relied on people's continence pads to manage people's continence needs as they did not have time to support people to go to the toilet. On the second day of inspection we saw staff offering

Requires improvement

Is the service responsive?

support and acting to manage people's continence needs. The district nurse service were also supporting the service to carry out a new assessment of all those with continence needs to ensure people's needs were being met.

We found staff had clear systems in place to ensure any reddening in people's skin was picked up quickly to prevent it developing into a pressure ulcer. People had body maps in place and staff recorded their actions clearly. The district nurse confirmed staff were quick to refer any concerns about people's skin integrity. We found pressure relieving equipment was in place and people were regularly turned or encouraged to get up and move where a concern had been identified.

People were not supported to follow their interests or prevent them becoming socially isolated. Activities were provided as a group activity approximately once a week. People could have their hair done by a visiting hairdresser. A member of the local clergy came once a month and people could attend a religious service at this time. People could have newspapers delivered. Feedback from people by means of questionnaires to the service had raised the issue of wanting more activities. Activities were not provided in line with people's needs or personal histories. However, one member of staff said: "I try to use people's personal histories to talk about where they are at; using the past to engage in care and to reassure people." All staff told us they had not had the time for people as they would like. Visits out of the service were only available to those who had family who could do this with them. One staff member said: "I met people's basic care needs; I could not do extra. If I wanted to do something special for someone that had to be in my own time" adding , "We did not have enough time to be creative; not enough stimulation. Nothing more for people or those who don't have relatives there for them." We discussed this with staff in charge and was advised the issue of activities was being reviewed as it had been recognised as not meeting people's needs.

Requires improvement

Is the service well-led?

Our findings

Restgarth is owned by Orchard Care (South West) Limited who own two care homes in the south west of England. There was a nominated individual in place who was also a director of the registered provider. A nominated individual is a person that is accountable and makes decisions at the provider level.

A registered manager was not in place to manage the service. A registered manager is required as part of a service's registration with CQC. A registered manager is important in making a difference to people's experiences of care. They are vital in helping to make sure people receive services that are safe, effective, caring, responsive and well-led. Management staff had been employed that included a manager and deputy manager. Both these staff had only recently started to work at the service and were in their probationary period.

CQC records showed we had not received any serious injury notifications for 2014 and 2015 to the date of the inspection. However the provider has advised there were no notifiable injuries that took place during this time.

The nominated individual attended the service weekly. Formal audits of people's experience and aspects of the service were completed in January 2015, February 2015 and July 2015. These were positive. They did not identify the concerns raised during the inspection. Prior to the inspection we had notified the provider of the concerns received. A senior management meeting was held on the 15 July 2015 to look at the running of both the provider's services. The provider had in place the practice that senior staff from each of their services reviewed each other's service to ensure they were maintaining a quality service. A further audit of Restgarth, during the week of the 20 July 2015, identified a number of issues.

People and their families were asked their view of the service and any changes they felt were necessary. Recently, this had been in the form of a questionnaire. Where issues were raised, there was no evidence of what action staff had taken. Staff in charge told us issues were addressed but not recorded. They told us they planned to reintroduce more informal opportunities for feedback and residents' meetings as these had lapsed recently.

There were regular staff meetings however, staff told us they had not felt listened to in relation to these. We saw the minutes of a staff meeting held in July 2015. At this meeting staff raised concerns about staff numbers. Staff told us this was not the first time they had raised concerns that they were not able to meet all people's needs due to there not being enough staff. Staff told us they had spoken with the nominated individual and previous managers but this had not resulted in staffing numbers being addressed. The nominated individual however, states staff had not told them about their staffing concerns.

Staff spoke with passion about the service and commitment to the people living there. They felt the second day of the inspection was different with more staff. One staff commented: "It is a new start". Staff told us the new staff in charge were approachable and they were feeling valued by being involved in writing the new care plans. Staff used words like "trusted" and "excited" to be given the opportunity to get to know people and their families in detail.

Audits to check aspects of the service had happened intermittently. Audits of care plans, falls, infection control and medicines had taken place but were not consistent. This had been identified and was being addressed.

There were systems in place to ensure the building and equipment were maintained. Contracts were in place to ensure equipment such as the passenger lift and stair lift were serviced regularly.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1) and (3)(a)(b)** **The registered person had not ensured people's care was appropriate, met their needs and reflected their preference by means of person centred care planning.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(1) and (2)** **People were not protected from abuse and improper treatment as system and processes were not established to prevent abuse of people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14(1) and (4)(d)** **Staff were not ensuring all people's nutritional needs were met by providing support to people to eat as necessary.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16(1)**

This section is primarily information for the provider

Action we have told the provider to take

All complaints were not investigated and action taken in response to any failure identified by the complaint or investigation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) and (2)(c) Sufficient numbers of suitably qualified staff were not employed and these staff did not receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.