T Lewis

Rosedene Nursing Home

Inspection report

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Date of inspection visit:
14 June 2016
16 June 2016
20 June 2016

Date of publication:
16 August 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We conducted an inspection of Rosedene Nursing Home on 14, 16 and 20 June 2016. The first day of the inspection was unannounced. We told the provider we would be returning for the second and third days. At our previous inspection on 7 August 2014 the service was meeting all regulations inspected.

Rosedene Nursing Home is a nursing home that provides care to up to 67 people with a broad range of health needs, with the majority having a diagnosis of a mental health condition. There are three floors to the building and people of different genders, mobility and mental health diagnosis were placed on each floor. At the time of our inspection there were 46 people using the service.

There was no registered manager at the service although the manager was in the process of registering with the 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.

Staff had completed medicines administration training within the last year and were clear about their responsibilities. However, staff were not recording the site at which they were giving people their injections creating the risk of causing people unnecessary pain by potentially injecting them in the same place and the date of opening on some topical medicines was not marked.

When questioned, staff appeared to be clear about safeguarding procedures and when to report an incident. However, we became aware of two safeguarding incidents which had not been reported or investigated and potential safeguarding concerns were not always addressed.

Staff told us they had received training in what to do in the event of an accident or incident, but most staff told us they had not received training in how to manage instances of violent aggression from people and the training records supported this. We observed one incident where a care worker did not manage a potential incident appropriately.

Information in care records and risk assessments was inconsistent and confusing. We found some examples of known risks not being fully explored through specific risk assessments and care planning as a result. We also found that staff did not always respond to risks appropriately to ensure that people were protected from avoidable harm.

Care staff gave us mixed feedback about whether they felt there were enough of them on duty to do their jobs properly. The manager was unable to provide us with evidence of how they determined safe staffing numbers or ensured that people with the right skills were on duty.

Recruitment records contained the necessary documentation to recruit staff safely.

The service was not compliant with the Mental Capacity Act 2005. We found examples of people being deprived of their liberty without having the necessary authorisations from the local authority. However, staff told us they had received training in the MCA and were able to demonstrate that they understood the issues surrounding consent.

Care records did not contain consistently up to date information about people's current healthcare needs.

Care records contained very little detail about people's life histories and some care staff lacked basic knowledge about the people they were caring for. Some care staff had very limited knowledge about some of the common mental health conditions people had and some staff providing one to one care were unable to explain why the person they were supporting required this level of care from them or what risk they were addressing by doing so.

People were encouraged to eat a healthy and balanced diet. People provided good feedback about the food available and the chefs were clear about what food they were required to prepare to cater for people's individual health needs.

Staff training records were incomplete so we could not be assured that care staff were receiving the mandatory training required to conduct their roles. Staff told us and records demonstrated that they were not receiving regular supervisions or appraisals of their performance.

We saw some examples of caring interactions between staff and people using the service. However, some of our observations were of a dismissive attitude towards people's care needs and we observed some instances of unkind treatment. We reported this behaviour to the manager who took appropriate action.

People's dignity was not protected. We saw some examples of care staff not respecting people's dignity.

People provided good feedback on the activities on offer. However, there was little evidence of appropriate activities provided for people to aid their therapy or rehabilitation

People and care staff gave mixed feedback about the manager. There was a complaints policy in place, but complaints were not responded to appropriately.

The organisation did not have good systems in place to monitor the quality of the service. There was no evidence of regular auditing being conducted.

During this inspection we found breaches of regulations in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, complaint handling, good governance and submitting notifications to the CQC. You can see what action we told the provider to take at the back of the full version of the report. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within

this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Care staff told us they were aware of how to recognise and what to do in the event of abuse taking place, however, not all safeguarding concerns were responded to appropriately.

Care staff told us they had been trained in what to do in the event of an accident, incident or emergency situation. However, staff did not know how to manage instances of aggression from people using the service to ensure that people were protected from avoidable harm.

Known risks were not appropriately managed or responded to.

There was mixed feedback from staff about whether they considered there were enough of them on duty to perform their roles properly. The manager could not demonstrate that there was an effective process for deploying staff in the service.

Staff were recruited safely and we saw evidence of appropriate pre- employment checks being conducted.

Is the service effective?

Inadequate

The service was not effective. The provider was not compliant with the requirements of the Mental Capacity Act 2005. We saw some examples of people's liberty being deprived without the appropriate authorisations in place from the local authority.

Staff training records did not demonstrate that care staff had received the mandatory training required to do their jobs. Staff were not receiving regular supervisions and appraisals of their performance.

Care records contained some information about people's health needs, but there were gaps in these records.

People gave good feedback about the food available but care records did not provide an up to date record of people's current nutritional needs.

Is the service caring?

Inadequate

The service was not caring. We saw some examples of good and caring interactions between staff and people using the service. However, we also saw some examples of unkind and uncaring interactions between some staff and people using the service. We found some staff attitudes to be dismissive of the needs of some people.

People's privacy and dignity was not always respected or promoted.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive. There was very little evidence that people were involved in decisions about their care.

The provider employed two activities coordinators to deliver an activities programme. Consistent records were not kept of people's involvement with activities. We did not see any evidence of activities being conducted to aid people in their recovery or rehabilitation.

The provider had a complaints policy and procedure in place. We asked the manager for a copy of their complaints records, but they told us they did not receive any complaints. During our inspection we became aware of two complaints which had not been handled appropriately by the manager.

Is the service well-led?

Inadequate

The service was not well led. Accidents and incidents were not recorded and followed up as required. There was no monitoring of accidents or incidents for trends or learning to improve the service.

Information was not reported to the Care Quality Commission (CQC) as required. We identified five safeguarding incidents and one serious injury which had not been reported to CQC as required.

The provider did not have adequate systems in place to monitor the quality of the care and support people received. We saw evidence of medicines audits conducted, but these had not identified the issues we found. There was no evidence of any other auditing taking place.

Rosedene Nursing 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 took place on 14, 16 and 20 June 2016. The inspection team consisted of an inspector, a specialist advisor 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. On this inspection the specialist advisor was a nurse with expertise in dementia care and mental health. The first day of our inspection was unannounced, but we told the provider we would be returning for a second and third day.

Prior to the inspection we reviewed the information we held about the service. We contacted a representative from the local authority safeguarding team and spoke with three more professionals who worked with the service to obtain their feedback.

During the inspection we spoke with eight people using the service. We spoke with seven care workers, three nurses, two activities coordinators, two chefs, the HR administrator, the clinical lead for the service who was the most senior nurse at Rosedene and the manager of the service. We looked at a sample of 10 people's care records, five staff records and records related to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. Their comments included "It's secure" and "I feel safe" and "There's usually staff in a room who can react."

However, despite these positive comments we found that people were not safe as staff did not always respond appropriately to safeguarding concerns to ensure that people using the service were protected from abuse. For example, on the first day of our inspection, we observed one person speaking inappropriately to another in a way that indicated this person may pose a risk to the other person. When we questioned the clinical lead about this, they told us that this occurred frequently and they did not consider this to be a risk or a safeguarding concern because they told us "It's just words" and they did not think the matter would escalate. They had also not considered how this behaviour may affect other people. Therefore we could not be assured that staff completely understood or recognised potential signs of abuse or understood their responsibilities with regards to reporting.

We saw a copy of a letter that had been sent by the manager of the service in response to a letter of complaint from a relative. In this letter, the manager of Rosedene alleged that they had been told by care staff that the relative had displayed abusive behaviour towards the person using the service. However, when questioned, the manager could not provide any evidence that they had followed this up or reported this incident to the local authority safeguarding team to ensure that the person was protected from harm. We referred this matter to the local authority safeguarding team.

We spoke with a member of the safeguarding team at the local authority and they told us they had some concerns about the monitoring of nursing staff at Rosedene by the management team as a direct result of a safeguarding investigation.

The above issues constitute a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding adults' policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training. Staff knew how to report safeguarding concerns and explained the various signs of abuse and different types of abuse. Care workers demonstrated knowledge of a recent safeguarding incident and knew about the changes that had been made to the person's care as a result of this. Care workers we spoke with confirmed that that they would report any concerns they had about people's safety and confirmed that they would whistle blow about any concerns if necessary. One care worker told us "I would report and whistle blow. Residents come first." Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

We looked at 10 people's care records. Initial information about the risks to people was included in an initial 'core' assessment which was provided from the referring social worker. Thereafter a 'pre admission' assessment was conducted by senior staff at the home and this included details related to the person's

physical and mental health. However, we found many examples of known risks not being fully explored through specific risk assessments which meant that risks were not always managed appropriately. For example, we were shown one person's care records by care staff because we were told this person had specific behaviour that challenged. We found a care plan which was specifically to do with the person's aggression. The aim of the care plan was recorded to be 'to control [the person's] aggression'. However, there was no recorded advice for care staff about how to manage this. The only advice for staff was to monitor the person's behaviour. There was also no evidence that external advice had been sought to manage the person's behaviour. In the most recent monthly evaluation of this care plan which was conducted in February 2016, the care worker had stated that the person 'seems to be easily irritated'. There was no further information about steps to be taken to support the person with their behaviour to protect them and others from harm.

We looked at another person's care records who had behaved inappropriately towards a member of the inspection team on the first day of our inspection. We had not been told about this person's behaviour despite us asking the clinical lead at the beginning of the day if there were any risks we should be aware of when speaking to people. We were told by a senior nurse that this was a known risk, however we found that this was not recorded in their care records. The clinical lead later told us that a similar incident had happened to another resident, "a long time ago" and there should have been a written record of this in the care file but they could not produce this. The clinical lead told us there was no risk assessment related to the possibility of this happening because they did not consider the behaviour a risk.

We found some examples of staff failing to respond to risks. For example, we were told by one person "I'm going to hurt myself." This person had a cigarette lighter in their hand when they told us this. We reported this to a member of staff who shrugged and made no attempt to remove the lighter. Upon checking this person's care record we found a risk assessment which said this person was not to be in possession of a cigarette lighter as they were known to smoke in their bedroom and considered to be at high risk of causing a fire in their room. The 'control measure' identified in this risk assessment was to 'check the service user for possession of lighter or matches'. We reported this matter to the manager of the service who assured us they had taken appropriate action.

Staff told us they received emergency training as part of their mandatory training which included what to do in the event of an accident, incident or medical emergency. Staff told us what they considered were the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. However, care workers demonstrated a lack of understanding in how to safely manage instances of violent aggression from people. Some care staff told us they had not received training in this. When we checked the training records we found there was evidence of only four out of 39 care workers currently employed having received this training. We observed one instance where a person became agitated and began to demonstrate this by shaking a railing which was in place to cordon off an area of the building. They were also holding a 'wet floor' sign. The care worker walked quickly away from this person and told us to do the same for our safety as they told us this person could attack us in their current mood using the sign. The care worker could no longer see where this person had gone. When asked where this person could be going and how the staff member could be assured of other people's safety, they were unable to provide us with an answer. They told us if the person became physically aggressive they would use one of the emergency call bells which were in place. However, when asked how the person's aggression would be dealt with at that point they were unable to provide an answer.

We found the environment to be unsafe. For example, we found an unattended bottle of bleach and broken furniture discarded within the home. This created a risk that people could use the items to harm themselves or others. We reported these matters to the manager who assured us these items had been cleared away.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were delivered on a monthly basis for named individuals in blister packs. Controlled medicines were stored safely for each person in a locked cupboard within a medicines storage room and other medicines were stored on different floors.

We also found in records we observed that there was no record made of sites where injections on the person's body were supposed to be given. This meant nursing staff could not be sure they were not causing unnecessary discomfort to people by injecting them in the same place.

We found some bottles of medicine were not marked with the date of opening. Therefore we could not be assured that these items could still safely be administered and had not expired.

We saw copies of monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify the issues we found.

We looked at the controlled drugs cabinets within the medicines storage room. We saw that controlled drugs were stored in an appropriately constructed safe which was locked. These medicines were recorded in a separate book and the amounts were checked and signed for by a nurse every day. We did a physical count of the controlled drugs and saw the amount recorded tallied with the amount available.

We saw examples of completed medicine administration record (MAR) charts for the month of our inspection. We saw that staff had fully completed these. We counted medicines for some of the people whose MAR charts we saw and saw that the amount of medicines available tallied with the amount recorded on the charts.

Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines.

Staff gave mixed feedback about whether they felt there were enough of them on duty to do their jobs properly. Their comments included "We seem to have more staff on the ground floor, but I do not know why", "There could be more staff", "There's never enough staff", "We're sometimes short staffed, but it usually gets sorted out, so there isn't a problem."

We asked the manager how they determined staffing numbers and they told us they worked in accordance with the guidelines on safe staffing levels as determined by the Royal College of Nursing. They told us their staffing levels were also based on people's needs. However, they were unable to evidence how they did this. They told us they had 12 care staff on duty during the day and 12 on duty at night, in addition to the Clinical Lead and Manager. However, this estimation did not match our observations during our inspection or our checks of the staffing rota.

We found in the four weeks prior to our inspection and for the week of our inspection, from a check of the service rota there appeared to be between eight to 10 care workers scheduled to work during the day and approximately the same number scheduled to work during the night. There were usually two nurses scheduled on each of these shifts. On the first day of our inspection there were 12 care staff on duty, but this included staff who were providing one to one care. Staff appeared to be rushed in the performance of their duties and we saw very few examples of staff taking time to speak with people. We observed one member of

staff sitting next to a person using the service with three other people in a lounge area. The person using the service wanted to get up out of the chair they were sitting in to walk around the building. When the person lifted their feet from the foot stool they were using the care worker put their hands on the person's ankles and guided their feet back to the stool. The care worker told us "There's just two of us here now. [The person] walks so much you have to follow him for ages."

The manager told us they tried to match staff based on their experience to appropriate floors. However we were told by the clinical lead during our inspection that people using the service were not placed on different floors or areas of the building according to their level of need and we could find no differentiation of people to determine where they were placed. One person with very high physical needs was placed near the nurses' station on the ground floor so staff could respond to them quickly in the event of an emergency, but there was no other known reason behind where other people were placed. Consequently we found people with different physical needs, ages, genders and mental health needs and associated risks were placed on any given floor and area of the building. This meant that staff were not allocated according to people's specific level of need.

We looked at the recruitment records for five staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms and for nurses this included their Nursing and Midwifery Council registration details.

There was an emergency call bell system in place to alert all staff in case of an emergency and this could be heard by staff in the entire building. We saw call bells were in place in people's rooms and that these were within reach and working. We asked nurses about what they would do in the event of a medical emergency and they explained what training they had done to respond to these situations. Nurses were aware who was for and was not for resuscitation. These details were in people's files on "Do not Attempt Resuscitation" forms which had been signed by their GP.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and found that the provider was not meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent. However, we saw examples of people's rights not being observed under the MCA. For example, we saw two people had bed rails in place. We asked to see DoLS authorisations in respect of these, but were told by the manager that applications for DoLS authorisations in relation to these decisions had not been made. We also saw two people had child gates in place in front of their bedroom doors and these were closed. We were told that one of these gates was in place to protect the person inside by preventing anyone from entering their room. Staff were unable to explain why the other gate was in place. When we asked to see DoLS authorisations for these we were told that these had not been applied for. We were told by the clinical lead that they would make applications for these as soon as possible.

We saw that exiting the building was via a key pad. This meant that people were not able to leave the building without asking staff for the code. We observed one person telling a care worker that they wished to leave. Care workers spoke with this person and we overheard them telling the person words to the effect that it was not the right time as it was raining. This person was therefore prevented from leaving the building despite requesting to do so. The clinical lead told us they felt everyone in the building ought to have DoLS authorisations in place as they were effectively restricting everyone's liberty by having a keypad exit in place.

We saw a record of another person who had a decision imposed on them for their own safety. We saw there was a note in their risk assessment which stated that the person 'lacks capacity and motivation'. However, when we asked the clinical lead whether any mental capacity assessments had been completed in arriving at this conclusion, they told us no. They told us they would conduct an assessment as soon as possible.

The above issues constitute a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the clinical lead that people living at the service had been sectioned under the Mental Health Act and were therefore being detained. We queried this with the manager and they confirmed that some people were receiving aftercare treatment under section 117 of the Mental Health Act, but were not being detained under any section of the act. However, we were not shown any evidence of this despite asking for documentation. Section 117 states that aftercare services must be provided to patients who have

been detained in hospital to meet their individual needs to minimise the chances of them being readmitted to hospital. Because senior staff could not show any documentation concerning anyone receiving care under this section and because we saw no reference to a care package being provided in accordance with this the provider could not demonstrate that they were providing people with the appropriate care to meet their needs to minimise the risk of them being readmitted to hospital.

People were encouraged to eat a healthy and balanced diet. People's care records included information about their dietary requirements, however, there was very limited information recorded about their about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. These included nutrition screening tools which were used to determine whether people were at risk of malnutrition. Based on this, people were monitored further or referred to specialists such as Speech and Language Therapists or dietitians. However, we found one example of a person's nutrition care plan not containing full details of their current needs. We found a 'prescribed food and fluid plan' which gave detailed instructions from a speech and language therapist (SALT) dated February 2014, but these details were not contained within the care plan.

We also found the instructions within the care plan to be unclear. One of the identified needs was that the person presented with 'excessive salivation'. The only recorded advice for staff was 'to monitor and assist if required.' Under the aims and objectives section it stated that the person 'will present with less salivation' but there was no explanation of how this could occur or how staff could achieve this.

Care records contained some information about people's health needs, but care records did not contain consistently up to date information about people's current healthcare needs. For example, we saw a copy of a complaint from a relative who complained that their relative had not seen the dentist for 7 years and had not received any physiotherapy despite them having suffered a stroke. We could find no record of them seeing a dentist or physiotherapist when checking their file despite the complaint being received in August 2015. We asked the manager about this and they could find no evidence that this person had been to see the dentist or physiotherapist since moving into the service.

Another person's mobility care plan stated that they need support from a physiotherapist as the person had suffered a fall approximately 11 months previously. However, there was no evidence of physiotherapy involvement and when questioned, care staff could not provide evidence of this.

The above issues constitute a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food available at the service. Comments included "Food is good. There's a good choice every day" and "I've just had a lovely lunch." We spoke with two chefs about the food available. They explained that they obtained feedback about the food from people directly and made changes according to their comments. The chefs provided us with examples of food people enjoyed and food people did not enjoy and had therefore decided not to cook again. We saw a copy of the menu for the month of our inspection. Food was seasonal and we saw different choices of food were offered for every meal. We sampled the lunch on the first day of our inspection. Food was appetising, of a good portion and served at the correct temperature.

We asked the chefs how they provided food for people's varying health needs. They told us what people's specific requirements and allergy information were, but also showed us a written table which contained this information, which they had to hand. They were clear about people's health needs and how they should prepare food to match these needs which included preparing meals of the correct consistency for those on

pureed diets.

The manager told us care staff completed training as part of their induction as well as ongoing training. Care staff confirmed they had completed training in mandatory topics such as safeguarding adults and dementia awareness training. The manager told us most staff had completed safeguarding training in March 2016 and Mental Health training had been provided in March 2016, but did not provide a figure on how many staff member attended this. When we looked at staff training records these were incomplete and did not demonstrate that all staff had completed mandatory training in all topics. We were initially shown a training spreadsheet which was incomplete and the manager told us to check staff training certificates in order to obtain an up to date account of who had conducted which training. However, when we checked all staff certificates that were available we found these did not demonstrate that all staff had completed mandatory training. These records showed less than half of care workers employed had received training in safeguarding adults, in fire safety and in moving and handling people. The records also showed that only four care workers had received training in 'physical intervention and breakaway techniques'. The manager told us that 25 people had attended this training in June 2016, but this took place after our inspection. There was therefore no up to date record to determine whether staff had completed mandatory training and this created a risk that care staff were conducting their work without having the relevant skills to do so.

Some people received one to one care from a dedicated care worker. When we spoke with these care workers they could provide very little detail about the person they were caring for. They were aware that they were supposed to be providing one to one care, but they could not tell us why they were doing this and what the risk was of not providing this care. There was also a lack of understanding among care staff about the people they were caring for. For example some care workers did not understand the mental health conditions people had. We asked one care worker what schizophrenia was as some of the people living at the service had this condition. They told us "They are just confused." Another care worker told us "I only realised this was a home for mentally ill people a few weeks after I started working." When we checked the training records only 11 care workers out of 39 were recorded as having received training in awareness of mental health conditions.

Some staff told us they felt well supported but only one out of five care workers we questioned about supervisions told us they were regularly receiving these. We saw records to indicate that staff supervisions were supposed to take place every two months. However, supervision records were incomplete and we did not see evidence that all care workers had received a supervision of their performance in 2016.

We were shown a record indicating the dates of the most recent supervisions conducted along with a sample of supervision records. The record with dates indicated that out of the 35 care workers listed only two had received a supervision within the last four months and only 10 had received a supervision in 2016. For 25 care workers, there was no record of a supervision ever having been conducted. We looked at five individual supervision forms. These included some aspirations for the future, but did not include any targets or objectives to help care staff to reach these. For example one person's supervision record stated that they 'would like external training' but it did not state which subjects the person was interested in or why they preferred the training to be external. Another person's record stated they would like 'ongoing personal development', but there was no indication as to what this would be.

The manager told us annual appraisals were conducted of care workers performance once they had worked at the service for one year. However, the manager was unable to provide us with evidence that most care staff had received an appraisal in the last year. Care workers told us they had not received an appraisal when we spoke with them.

The above issues constitute a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People who used the service gave us good feedback about the care workers. Comments included "They give me help when I need it" and "They joke with me. That's how they get to know me." However, despite these comments our observations of the care provided was mixed. We saw some examples of good and caring interactions between staff and people using the service. However, we also saw some examples of unkind and uncaring interactions between some staff and people using the service.

We found some staff attitudes to be dismissive of the needs of some people. For example, one person spent a large part of the first day of our inspection shouting for help and walking up and down the corridor of the ground floor. This person had limited sight and appeared to be in a distressed state for a large part of the day. When we asked if this person needed help one care worker told us "that's [person's name]. He/she does that." We saw this person being moved out of the way by care workers without explaining what they were doing in order to walk past them. At one point we heard one care worker tell another "Can you please explain to him why you are holding his hand. Tell him why you need him to move." Later in the day we observed one care worker approach this person and speak kindly to them. They responded by speaking calmly in return and appeared to be grateful for the assistance.

At another point in the day we observed a person using the service to shout at another person in front of care staff. This person appeared to be upset at being shouted at, but the care worker did not respond to this.

We observed one care worker's interactions with people throughout the day and found their behaviour to be consistently unkind. We reported this behaviour to the manager who has taken appropriate action. Examples of the behaviour this person demonstrated were that whilst standing with two other members of staff they gestured to a person using the service, laughed and told us the person was difficult. They also mimicked a person's behaviour in front of them and spoke about them in a derogatory manner. Then using their hand to push the person's hair to one side and pulling at their jumper which had some stains on it the staff member said, "Look at the state of you." A few moments later the care worker gestured towards the same person and told us "Look at her, look at her. She's getting ready to throw the cup away. She's naughty this one."

We observed this care worker giving this person their lunch. They did not explain what food they were giving the person. We observed the care worker to speak to other members of staff loudly whilst assisting the person. They fed the person quickly. For a number of bites we observed the person had not finished the previous spoonful of food before another spoonful was being placed into their mouth. The person raised their hand twice and the care worker, raising their voice, responded loudly "Hand down [person's name]. Put your hand down." The care worker used their hand to push the person's hand down, turned to us and said "You see that?" Then turning back they said loudly to the person "Behave yourself." `

People we spoke gave us mixed views about whether their privacy and dignity was respected. One person told us, "They knock on my door. I only like a man helping me with showering and they usually sort that", but also added, "The laundry gets in a muddle even though it's named" and another person said ""My

clothes get lost, mixed up. They are my personal things."

Care workers explained how they promoted people's privacy and dignity. Their comments included "When I'm giving personal care I will draw the curtains and explain to people what I'm going to do" and "I will keep private conversations confidential so people can trust me." However, despite these comments we observed people not being treated with due regard being given to their dignity. For example we observed one person walking with their trousers down, exposing their incontinence pad. Care staff did not pay any attention to this person. We also noticed three people spent a large proportion of the first day of the inspection sat in the same seats within one of the lounge areas. We observed them to be in these seats at approximately 10am and they were still in these seats at approximately 5pm. At different points in the day two of these people had urinated through their pads and clothing and had to be led out of the room to be changed into clean clothing. We spoke to a care worker after the second person had to be led out of the room and asked them whether they were taken to the toilet throughout the day. They told us these people were unable to tell them when they needed to go to the toilet and said "These people are like babies."

The above issues constitute a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that people were given a brochure telling them about the service when they first moved in. The manager told us residents and relatives meetings were held on a quarterly basis. We saw minutes of the two previous meetings which had taken place which we were told were joint meetings. However, we did not see any recorded comments from people using the service within these minutes because we were told all the service users who attended were non-verbal. When we spoke with people using the service only one person was aware these meetings took place.

Some staff did not demonstrate a good understanding of people's life histories. Senior staff and care workers told us they asked questions about people's life histories and people important to them when they first joined the service, but we found very limited examples of this being recorded in the care records we viewed. There was some reference to people's country of origin when it was not the UK and there was some information about people's family and people important to them when this was relevant to other aspects of their care, but there was no comprehensive document detailing how people had come to live at the service and what events in their life had contributed to their current circumstances.

Care records demonstrated that people's cultural and religious requirements were considered when people first started using the service. There was a written record of people's cultural and religious needs recorded in their care records. We found three examples of people's cultural and religious needs being met, for example the chefs told us they prepared food from one person's country of origin as they knew they would enjoy this. We were also told that religious services were held at Rosedene.

Requires Improvement

Is the service responsive?

Our findings

There was very little evidence that people were involved in decisions about their care. When we asked people about their care plans only one person had any awareness of this document. They told us "Within two weeks I was asked a lot of questions and I think it was for my care plan." However, this person was not aware of what was contained within their care plan.

In one person's care record the 'intervention' recorded in their 'communication' care plan was that care staff were required to 'discuss needs and wishes' of the person. However, there was no further evidence that this was done.

There was evidence that people's needs were assessed by senior staff member before they started using the service and there was initial information about the person from the referring social worker. Care plans were then completed in areas of perceived need. Progress was supposed to be reviewed on a monthly basis, but this was inconsistent.

The service employed two full time activities coordinators to deliver an activities programme to people using the service. The programme included live music, bingo, chair based exercises for people with mobility problems and arts and crafts. People gave good feedback about the activities on offer. Comments included "Two activity people can do a good bingo". "We had a lovely garden party for the Queen's birthday" and "I like the films they show and you can choose the film."

The activities coordinators spoke with people and obtained their feedback in relation to activities. However, people's involvement in activities was not consistently recorded. Activities coordinators recorded which activities some people attended and whether they enjoyed them. Some people also had dedicated activities care plans which included details of which activities people enjoyed, what their aim was in relation to participation with activities and monthly reviews of their participation with the activities programme. However, there was no evidence that activities coordinators were proactively working with people to meet their aims in relation to activities. We also requested four activities care plans, but were told they had not been produced.

We did not see any evidence of activities being conducted to aid people in their recovery or rehabilitation. We saw one care worker throwing objects in the air and trying to engage a person using the service when doing so. However, when we asked the care worker the purpose of this activity they were unable to provide an explanation.

We viewed the care records of two different people who had been identified as requiring encouragement with activities as part of their rehabilitation. When we questioned the lead activities coordinator about these people they could not provide evidence of any involvement with either of them. There was no evidence of care planning or any activities conducted with them.

The above issues constitute a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The service had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We requested records of complaints from the manager and were told that there were no complaints because people did not complain. However, when checking care records we found a copy of an emailed complaint from the relative of a person using the service within the care file. This was an email chain between the manager and the relative. The relative had sent an initial emailed complaint which the manager had responded to. The relative then responded by sending a comprehensive and detailed complaint which did not appear to have a response. When we asked the manager about this complaint they were unable to provide a copy of their response to the complaint and told us they did not think one had been sent.

We were also sent a copy of a response to a complaint written by the manager from an unknown source. We requested a copy of the original complaint letter from the manager, but they did not provide this. The complaints responses we saw demonstrated that the manager had not managed complaints appropriately.

The above issues constitute a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Staff and people using the service gave mixed feedback about the manager. Some people were not sure who the manager of the service was and one person told us "She blows hot and cold with me." Care workers told us, "[We] cannot talk to management", "She is not very approachable", "Some residents only want to speak to [the manager], but she is often not available. She doesn't speak to residents. That is a concern for quite a lot of staff", "She is a good manager" and "she tries".

We observed that the manager was not visible around the home throughout our inspection and had limited interaction with people. We observed her attempting to de-escalate a situation, but had to be prevented from inadvertently escalating it by another care worker. This was because the manager was not aware of the potential triggers that may have caused the person distress. Some of our requests for information were not responded to by the manager both during and after our inspection.

We saw evidence that feedback was obtained from people using the service in the form of questionnaires. We saw copies of questionnaires and saw these were positive about the care provided. We were told that the activities coordinators discussed the results of any issues identified through feedback in resident meetings. We were told feedback was received during residents meetings, but most people we asked were not aware these were happening and the meeting minutes did not record any comments from the people who attended.

We saw records of two complaints, and accident and incident records. We identified two examples of accidents and incidents which had not been recorded on the appropriate forms and where there was no evidence of a follow up investigation being conducted. The forms included details of the accident or incident which occurred and any follow up actions conducted. In one example, one person using the service injured another person and in another example a person using the service had attempted to injure a member of the care staff. We saw notes relating to these incidents within people's care records, however, there was no evidence of the matters being investigated or of risk assessments or care plans being updated as a result.

There was no evidence that accidents or incidents were monitored or analysed to inform learning and to help improve the service and care records did not provide an up to date record of people's current healthcare needs. The provider did not have adequate systems to monitor the quality of the care and support people received. We saw evidence of medicines audits conducted, but these had not identified the issues we found with medicines. The manager told us it was the clinical lead's responsibility to conduct audits, although they had only been in post for one month. They told us that they intended to conduct various audits in the future but had not yet done so. The manager was unable to provide evidence of any other audits being conducted and had failed to identify the shortfalls that we found during our inspection. Therefore there was a lack of effective leadership and monitoring of the service to ensure that people received safe care that met their needs.

The above issues constitute a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Information was not reported to the Care Quality Commission (CQC) as required. We identified five safeguarding incidents and one serious injury which had not been reported to CQC as required. We spoke with a member of the local authority who provided us with a list of safeguarding investigations which had been conducted since December 2015. We also tallied the provider's record of safeguarding incidents against the information we had been sent.

The above issues constitute a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

The provider sometimes worked with other organisations when delivering care to people. We saw some evidence in care records that showed work being conducted with local multi-disciplinary teams, which included the Behaviour and Communication Support Services, the GP, Trinity Hospice and local social services teams among others. We spoke with two health care professionals and they commented positively on their working relationship with staff at the service.

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 18 Registration Regulations 2009 Notifications of other incidents You had failed to notify the commission about safeguarding concerns. (Regulation 18(1)(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always provide care in accordance with the 2005 Act. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users receiving the care or treatment and did not do all that is reasonably practicable to mitigate any such risks. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)(2)

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 The provider did not investigate immediately upon becoming aware of allegations or evidence of abuse. Regulation 13(3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not investigate and take necessary and proportionate action in response to complaints made and did not operate an accessible system for identifying, receiving, recording and handling complaints by service users and other people in relation to the carrying on of the regulated activity. (Regulation 16(1)(2)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems and processes to assess and monitor the quality and safety of the service or to assess, monitor and mitigate risks to service use. Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff received the appropriate training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. (Regulation 18(2)(a)).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that care and treatment was appropriate and met the needs of service users. Reg 9 (1) (a) and (b)

The enforcement action we took:

A Warning Notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure service users were protected from improper treatment or neglect and did not ensure that service users were treated with dignity and respect. Reg 10

The enforcement action we took:

A Warning Notice was issued