C.N.V. Limited

Rosecroft Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 16 and 17 January 2017. This inspection was prompted in part by a notification of incidents and concerns regarding people's care and welfare. These incidents are subject to a criminal investigation and as a result this inspection did not examine the circumstances of these incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk and safe care and treatment of people using the service. This inspection examined those risks.

Rosecroft Residential Care Home is a small care home that provides personal care and support for up to 20 people and it is located in the London Borough of Bromley. At the time of our inspection the home was providing care and support to 13 people. The home had a registered manager in post who was not present at the time of the inspection; however an acting manager was in place at the time of our inspection. 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.

At this inspection we found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014. We took urgent enforcement action to impose conditions to restrict new admissions to Rosecroft Residential Care Home. We required the provider undertakes audits of medicines, risk assessments, care plans and records of care delivery for people using the service, systems for staff recruitment and an action plan of the training of all staff at Rosecroft Residential Care Home. The provider must tell CQC any action they have taken or will take as a result of the audits. The provider must continue to provide us with such reports following each and every audit undertaken in respect of these matters.

For time periods since the last inspection we found that medicines were not managed, administered, recorded and stored safely and appropriately. Risks to people's physical and mental health needs were not assessed, monitored and reviewed in line with the provider's policy. Accidents and incidents were not recorded and acted on appropriately. Safeguarding adult's policies and procedures were in place to help protect people from possible harm; however concerns had not been reported to local authorities and the CQC in line with best practice and the law. Staff recruitment practices in place were not robust and appropriate recruitment checks were not always conducted before staff started work to ensure applicants were suitable to be employed in a social care setting. There were arrangements in place to deal with foreseeable emergencies and staff knew what to do in the event of a fire or a medical emergency, however there were no up to date fire drills and evacuations conducted. There were no records of maintenance checks or repairs in place to monitor the safety of the environment and equipment.

Staff had not received appropriate regular training to meet the needs of people using the service. There were no records or systems in place to show that staff new to the home had completed an induction into the service in line with the Care Certificate. The Care Certificate sets out learning outcomes, competencies and

standards of care that are expected of all care workers. Staff had not received appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. People's mental capacity and consent was not always assessed in line with the MCA and were not always decision specific. People's nutritional needs were not always assessed and met appropriately. People did not always receive the support they required to access health and social care services.

People's care and support needs were not always reviewed in line with the provider's policy on a monthly basis and in response to people's identified needs. People and their relatives told us there was not always enough stimulation and activities on offer at the home. Although there were policies in place to manage and responded to complaints, complaints records were not appropriately recorded or maintained.

People told us that staff currently working at the service were kind and respectful and supported them appropriately but we found this had not been consistently the case. Staff respected people's choice for privacy and promoted their dignity when offering support. Staff showed their knowledgeable about people's needs and supported people appropriately. People were supported to maintain relationships with their families and friends and their independence when venturing out was encouraged. People and their relatives told us they were provided with information about the home in the form of a service user guide.

People and their relatives told us of the recent instability in staffing and leadership at the home and how this had an impact on the care provided. Staff meetings were not held and recorded on a regular basis to ensure safe practice and leadership. Resident meetings were not held on a regular basis and there were no action plans or records in place to show how people's comments had been addressed. Audit checks had not been conducted within the home prior to the arrival of the acting manager to assess, monitor and improve the quality and safety of the service. Audits that were conducted failed to identify and address concerns and issues and although the provider had sought feedback from people using the service there was no action plan in place or records to show that people's comments or requests for service improvements had been addressed. The provider failed to notify the CQC as they are required to do, of significant events in order that CQC can monitor the service.

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, it 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 may 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. 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.

Medicines were not managed, administered, recorded and stored safely and appropriately for substantial periods of time.

Risks to people's physical and mental health needs were not assessed, monitored and reviewed in line with the provider's policy.

Accidents and incidents were not recorded and acted on appropriately.

Systems were not in place to protect people from abuse and concerns had not been reported to local authorities.

Staff recruitment practices were not robust and appropriate recruitment checks were not always conducted before staff started work to ensure applicants were suitable to be employed in a social care setting.

There were arrangements in place to deal with foreseeable emergencies; however there were no up to date fire drills and evacuations conducted.

There were no records of maintenance checks or repairs in place to monitor the safety of the environment and equipment.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received appropriate regular training to meet the needs of people using the service.

There were no records or systems in place to show that staff new to the home had completed an induction into the service in line with the Care Certificate.

Staff had not received appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

People's mental capacity and consent was not always assessed in line with the Mental Capacity Act 2015 (MCA). The MCA provides protection for people who do not have capacity to make decisions for themselves.

People's nutritional needs were not always assessed and met appropriately.

People did not always receive the support they required to access health and social care services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that the current staff team were kind and respectful and supported them appropriately however this had not been the case consistently.

The current staff team respected people's choice for privacy and promoted their dignity when offering support.

People were supported to maintain relationships with their families and friends.

People and their relatives told us they were provided with information about the home in the form of a service user guide.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care and support needs were not always reviewed in line with the provider's policy on a monthly basis and in response to people's identified needs.

People and their relatives told us there was not always enough stimulation and activities on offer at the home.

Although there were policies in place to manage and responded to complaints, complaints were not appropriately recorded or maintained.

Is the service well-led?

Inadequate

The service was not well-led.

There was an acting manager in post at the time of our inspection.

People and their relatives told us of the recent instability in staffing and leadership at the home and how this had an impact on the care provided. Staff meetings were not held and recorded on a regular basis to ensure safe practice and leadership.

Resident meetings were not held on a regular basis and there were no action plans or records in place to show how people's comments had been addressed.

Audit checks had not been conducted within the home for many aspects of the service prior to the arrival of the acting manager and current staff. Audits that were conducted failed to identify and address concerns and issues we found during our inspection.

The provider sought feedback from people using the service, however there were no action plans in place or records to show that people's comments or requests for service improvements had been addressed.

The provider had not notified CQC as they are required to do, of significant events and deaths in order that CQC can monitor the service.

Rosecroft Residential Care 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was prompted in part by information of concern regarding people's care and welfare.

Prior to the inspection we reviewed the information we held about the service. This included looking at statutory notifications. A notification is information about important events which the provider is required by law to send us. We spoke with local authorities and health clinical commissioning groups who commission the service and local safeguarding teams. We also spoke with other health and social care professionals to obtain their views. We used this information to help inform our inspection.

The inspection was unannounced and consisted of a team of three. On the 16 January 2017 the team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the 17 January 2017 one inspector returned to the service.

During the inspection we spoke with five people using the service, three visiting relatives and two visiting professionals. We spoke with five members of staff including the acting manager, care staff, kitchen staff and the provider's auditor. We looked at the care plans and records for all 13 people using the service and eight staff records.

Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) to observe people's experiences throughout the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection we looked at records and reviewed information given to us by staff. We looked at care plans and records for people using the service, medicine records and records related to the management of the service including audits and incidents logs. We also looked at areas of the building including communal areas and outside grounds.

Inadequate

Is the service safe?

Our findings

People using the service told us they felt safe with the staff that supported them and they were supported to take their medicines as prescribed. One person said, "Yes, I feel safe, I would say if I was not. There are no problems here and I think I have tablets." Another person said, "Yes, I do feel safe." A visiting relative commented, "There are different staff now, we feel more confident about our loved ones safety, their safety is very important to us. We believe our loved one is getting their medication."

Although people told us they felt safe and they received their medicines as prescribed we found that this had not been consistent and medicines were not always administered and managed safely. We looked at the arrangements in place for the management, administration and storage of medicines. Systems in place prior to the 23 November 2016 were not robust, effective and safe. Medicines Administration Records (MARs) for people using the service showed us that medicines management and administration was not safe.

We looked at the medicines records for all people using the service who were receiving support with medicines. We saw that Medicines Administration Records (MAR) had not been completed for 11 people using the service from 21 November 2016 to the 23 November 2016 inclusive. It could not be established if people received their medicines as prescribed by health care professionals on these days.

We saw that for one person their MARs had not been completed for the period from 24 October 2016 to 20 November 2016 inclusive. Another person's MARs had not been completed for the period from 24 October 2016 to the 20 November 2016 inclusive. A third person's MARs had not been completed for the period from 29 August 2016 to the 25 September 2016 inclusive. A fourth person's MARs had not been completed for most of the month, period from 29 August 2016 and there were only two days when the MAR was completed on the 29 and 30 August 2016. A person who required a specialist medication for a blood clotting disorder did not have their medicines recorded appropriately and test results in order to ensure the medication dosage was correct. Another person on a similar type of medicine did not have a completed MAR for the period 24 October 2016 to 20 November 2016. Medicines were not managed safely in order to ensure people received their medicines as prescribed by health care professionals.

Medicines had not been stored in a safe way to ensure they were effective when used. We noted that an external pharmacist visited the service and carried out an audit on the 22 January 2016 and more recently on the 9 December 2016. They highlighted that checks and temperature recording for medicine refrigerators were not always recorded and room temperatures where the medicine trolley was stored were noted to be above 25c which is not in line with safe storage. Therefore it could not be established if medicines were fit for use.

These issues are in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's physical and mental health needs were not assessed, monitored and reviewed to ensure risks were managed. We looked at the care plans and records for all 13 people using the service and found

risk to the health, safety and welfare of people were not monitored or action taken to manage identified risks. For example one person's care plan and risk assessments were last reviewed in May 2015 and were not reflective of the person's current care needs. We saw a dietitian's care plan for a person with difficulty swallowing dated July 2015 which provided staff with guidance to monitor the person's nutrition and weight. However monthly weight monitoring charts were last completed on the 28 May 2015. A dietetic assessment conducted on the 19 December 2016 noted that the person had lost 4kg in weight. There were no records to show what action had been taken to identify, monitor and address the person's weight loss.

Another person's care plan and risk assessments were last reviewed on the 09 January 2017 but previously only on the 22 July 2016 and the 19 October 2016. We saw there was a body map in place to record any wounds or injuries dated 21 July 2016 for a pressure ulcer, however no further information on the person's treatment or progress was recorded and there was no wound care plan in place. No monitoring of the person's pressure ulcer had been conducted to reduce the risks associated with this condition. Monthly weight monitoring records had only been completed once on the 01 July 2016 and therefore it is unknown if the person received appropriate nutritional needs and care. We noted there was a hospital discharge letter contained within the persons care records regarding a fall the person had suffered on the 2 October 2016. However no further information or records of the fall or any injuries sustained were documented to allow monitoring and risk assessment to support staff in managing further risks. A body map dated 20 December 2016 documented bruises suffered to the person's hands; however no further information or treatment plan was in place. We noted that their mobility and falls risk assessment were last reviewed on the 22 July 2016 and records stated that the person had no known history of having fallen in the last 12 months despite incident records showing the person had fallen on 3 January 2016. This meant any assessment of risk was not based on accurate information and would not support risk management.

A third person's care plan and risk assessments were last reviewed on the 11 August 2016 and not on a monthly basis as the provider's policy states they should be. Monthly weight monitoring records were last conducted on the 11 August 2016 and stated the person was underweight and required supplements. However no further monitoring of their weight was conducted to ensure their weight was in a healthy range. We noted the persons care file contained a hospital admission form regarding a fall they had suffered on the 29 February 2016; however no further information was recorded regarding their care or treatment following this fall. There was another hospital admission form regarding another fall suffered by the person on the 13 July 2016 but no further information was recorded on the incident or any injuries sustained. When the person's risk assessments were last reviewed on the 11 August 2016 they stated the person had no known history of having fallen in the last 12 months despite hospital records showing falls suffered in February and July 2016.

These issues are a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were not recorded and acted on appropriately. Records showed that staff had identified concerns but appropriate actions to address concerns and respond appropriately to people's health and care needs were not always taken. For example an accident record dated April 2016 recorded that one person was suspected of suffering a fall in their room. No further information was provided on the actions taken or treatment provided. Accidents and incidents were not always referred to local authorities and the CQC as required and advice was not always sought from health care professionals when required to ensure peoples well-being and safety.

These issues are a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff employed at the service at the time of our inspection were aware of the potential types of abuse that could occur and the actions they should take to protect people from possible harm. Staff were also aware of the provider's whistle blowing procedure and how to use it to alert issues of poor practice and concerns. However systems and processes had not been operated effectively to protect people from abuse. We spoke with the acting manager and asked to see the safeguarding policies and records kept at the home. They advised us that there were no safeguarding records in place kept at the home and showed us a safeguarding folder which contained out of date policies. Records for people using the service that we looked at demonstrated that concerns within the service were evident; however no action had been taken to report the concerns to local authorities.

These issues are in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Commission are in receipt of information related to concerns at the home and these incidents are subject to further investigation by other authorities and as a result our inspection did not examine the circumstances of the incidents.

Staff recruitment practices in place were not robust and appropriate recruitment checks were not always conducted before staff started work to ensure applicants were suitable to be employed in a social care setting. Staff records we looked at showed that some pre-employment checks were not always carried out before staff started work. For example one staff members' file showed that they commenced employment in October 2016, however there were no references on their file and there were gaps in their employment history between 1991 and 2015 that had not been explored to confirm that they were suitable for employment. Another staff file showed that the member of staff commenced employment in October 2016 and again there were no references on their file to ensure they were suitable to work within the service.

These issues are in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We drew these omissions to the acting manager's attention who took appropriate actions to source the required staff information following our inspection.

There were arrangements in place to deal with foreseeable emergencies and staff knew what to do in the event of a fire or a medical emergency. An external fire risk assessment for the home was up to date and last carried out in September 2016. Weekly fire alarm tests had been carried out since 1 December 2016; however no up to date fire drills and evacuation had been conducted since 2 July 2015 which was identified in the fire risk assessment conducted in September 2016. There were no records of maintenance work carried out at the home in place. The acting manager advised us that they verbally notified the maintenance person when repairs were required but there were no records of maintenance checks or repairs in place to monitor the safety of the environment and equipment.

These issues are in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we drew these omissions to the acting manager's attention who informed us after the inspection that they had taken appropriate actions to ensure up to date fire training for staff was sourced and fire drills were planned to take place.

Inadequate

Is the service effective?

Our findings

At the inspection we found many shortfalls in the care and treatment provided to people using the service and we found staff had not been supported through appropriate regular training to meet the needs of people using the service.

Not all staff had received training in order to meet people's needs. We looked at records from the providers on line training system which listed 14 different training programmes available to staff working at the service. Records showed that five members of staff had not completed any recent training courses. For example one member of staff last completed 11training courses in March and July 2015. Another member of staff last completed 1 training course in April 2015 with no further records of training received or completed. A third member of staff had no records or evidence of training completed since their employment and a fourth staff member also had no records or evidence of training received or completed.

Staff did not receive appropriate support, supervision and appraisal to enable them to carry out their duties and meet people's needs. We looked at four staff files available to us during our inspection and noted that two staff members last received supervision on 27 September 2016. Another two staff files had no record or verification of supervision having been conducted at all. The acting manager confirmed to us that supervision records should be contained within staff files and the providers supervision policy stipulated that supervision would take place at least two monthly.

These issues are in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff asked for their consent before they provided personal care and during our inspection we observed this to be the case. One person said, "They [staff] always ask me. They are very good." Staff provided us with examples of how they sought peoples consent and demonstrated good knowledge and understanding of people's rights to make informed choices and decisions independently but where necessary for staff to act in someone's best interest.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that where required, people's care plans contained assessments of people's ability and understanding to make informed decisions, however we noted that these were not always decision specific and many had not been reviewed for some

time. For example one care plan detailed that the person was able to make some decisions that affected their day to day activities such as choosing what to wear but complex decisions would be difficult. It stated that a mental capacity assessment and associated care plan should be used to assess the person's needs; however this was not contained within their care plan. This required improvement. We noted that DoLS were applied for where appropriate in line with the MCA and saw that these were in place for some people using the service at the time of our inspection.

People told us their preferences at meal times were met and they thought the food on offer was satisfactory. One person told us "I don't always like the food but I do ask for different dishes." Another person said "The food's ok, there's enough choice." A third person commented, "I quite like the food. There is always plenty to drink." A visiting relative commented, "My loved one doesn't like the main courses much, but they like the desserts." However we found concerns regarding people's nutrition which appear in the safe and responsive sections of our report.

We saw menus were discussed with people using the service ensuring a balanced diet that reflected their dietary needs and preferences. We observed staff used picture cards in the dining room which displayed pictures of daily food menu options to aid understanding and to assist with choice. A member of staff told us, "We use pictures to show residents the meal options at their tables. They choose their menu at meal times so they know what meals they are eating and we try to accommodate their likes and dislikes." We observed lunch time in the dining room and saw people were offered choices and staff chatted with them whilst serving meals. People sat either with a member of staff or with other people using the service and did not eat alone. Staff supported people with their meals and provided conversation and encouragement when offering support. Throughout our inspection we observed that people were provided with sufficient amounts of foods and drinks to meet their needs including fresh fruit and cakes between meals. However we noted that food and fluid charts for people using the service were not always completed in detail to monitor the types of foods and amounts people ate. For example one person's food chart recorded that they had only eaten a small amount that day but failed to record what foods had been offered or eaten and what amount. This meant that risks regarding the person's nutritional intake might not be identified. This required improvement. We also noted that food and fluid charts had only been kept since 28 November 2016 and we were therefore unable to check if people's nutritional needs were fully met prior to this date.

People and their relatives told us they could see health and social care professionals when required in order to meet their needs. One person said, "If I'm not well staff call the doctor." Another person said, "I've not been unwell, so not needed the GP." A visiting relative commented, "My loved one sees a chiropodist and the hairdresser visits. The GP is called when residents are not well." Although some people were able to tell us that they received health and social care professionals support when required records and care plans we looked at demonstrated this was not always the case. For example one care plan had no record of health care professional's visits and involvement despite the person having a history of falls and injuries. The provider therefore failed to work effectively with others to ensure that care and treatment remained safe for people using the service and this is dealt with in the safe section of this report.

Requires Improvement

Is the service caring?

Our findings

People told us that the current staff were kind and respectful and supported them appropriately. One person said, "Staff are nice to me, they are all kind to me. I am happy with the way people are looked after." Another person commented, "The staff are mainly kind to me. I like most of those who work here." A third person said, "The staff are pretty easy going, good to get on with. The staff are very respectful." However staff working at the service had not been consistently caring and this required improvement.

Visiting relatives told us they were generally happy with the care their loved ones received and they had noticed improvements within the home since the changes in staff in November 2016. One relative said, "Staff are now caring and more willing and seem to be checking on our loved one more. Before the problems, they were not communicating with the family, but now they are. Our loved one seems much better now, awake and their clothes are clean. They look better and have put on weight." Another relative commented, "Staff could be more cheerful with our loved one, they are fine with me. Since the change, our loved one is wearing their own clothes, and not someone else's. They groom our loved one regularly now and they are keeping their hair tidy now as well."

Throughout the course of our inspection we observed that communal areas were relaxed and welcoming and staff encouraged and supported people with activities of daily living and with participating in planned activities. We saw that staff actively listened to people and supported and encouraged them to express their views and to be involved in making decisions about their support and meeting their needs. Staff addressed people by their preferred names and answered people's questions with understanding and patience. Staff we spoke with had a good understanding of people's life histories and preferences and were able to tell us about important events in people's lives and about people's individual personalities and behaviours.

The current staff team were observed to respect people's choice for privacy and promote their dignity when offering support. Throughout the course of our inspection was saw that staff understood people's needs even though there had been some changes in the staff team, existing staff shared their knowledge and experience of people's needs and preferences with new staff. One member of staff told us, "I always close doors and curtains and make sure people are covered when I am carrying out personal care." Another staff member said, "I always speak to people in their rooms with the door closed to keep matters confidential and private." Staff responded to people sensitively when offering support and told us where possible they encouraged people to remain independent. One member of staff said, "I encourage people to dress and wash themselves." Another member of staff told us, "I encourage people to choose their meals."

People were supported to practice their faith and to attend services that were offered on a weekly basis within the home. Where appropriate people's relatives were involved in their family member's care and were invited to attend meetings and events when held. People were supported to maintain relationships with their families and friends and their independence when venturing out was encouraged. One person told us, "I do get out a bit with my family. I do try to do things for myself and I go to a day centre twice a week." Another person commented, "On the whole, I feel they [staff] give me independence." Throughout the course of our inspection we observed visitors coming and going without restriction. People and their

relatives told us they were provided with information about the home in the form of a service user guide that included the complaints procedure.

Requires Improvement

Is the service responsive?

Our findings

People's care and support needs were not always reviewed in response to changes in people's identified needs. For example one person's care plan was last reviewed on the 28 October 2014 and was therefore was not reflective of their needs as monthly weight monitoring charts were last completed on the 29 May 2015. A health care professional visited and reviewed the person's care on the 17 November 2016 and recorded that their weight had increased by 3kg but nutritional supplements were still required to support weight gain. No further reviews in relation to the person care needs were conducted and retained within their file.

Another person's care plan was last reviewed on the 12 January 2017; however some of the sections of the care plan were last reviewed on the 16 September 2016. Monthly weight monitoring records were last conducted on the 16 December 2016 which recorded a minor weight loss. However there were no previous weight monitoring records for the person and their daily care records which were kept on the provider's computer system only recounted records from 01 January 2017 to the 31 January 2017. This meant that the provider failed to assess and monitor risks relating to the health, safety and welfare of people using the service and had not been responsive to people's needs.

These issues are a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and external entertainers provided a range of activities that people could choose to engage in. However at the time of our inspection there was no dedicated activities co-ordinator in post and staff supported with activities when available. The acting manager told us they were looking to employ a full time activities coordinator who would develop a range of activities suited to people's needs and interests. People and their relatives told us there was not always enough stimulation and activities on offer at the home. One person said, "There's not a lot of entertainment here. I get out when my partner takes me." Another person told us, "We get entertainment sometimes." A visiting relative commented, "Normally there is very little entertainment. All the time the tape is on with music and also the TV, but there is no relationship." Another relative said, "Now, we believe our loved one is getting the care they should and they play ball sometimes and go out in a mini-bus."

During the afternoon on the first day of our inspection we observed that the provider had booked an external activities person to visit the home and get people involved in ball games, chair exercises and singing. We saw that most people participated in the arranged activities but some people preferred to go to their rooms or to sit quietly and talk with staff. During the second day of our inspection we saw that staff initiated a variety of activities including skittles, board games and time spent with people on an individual basis doing activities of their choice, for example staff reading the daily newspaper to one person. However this required improvement in order to consistently provide meaningful activity for people.

The provider had a complaints policy displayed on notice boards within the home. Most people we spoke with told us they were aware of how to make a complaint and would tell a member of staff or the manager if they had any concerns. One person said, "I don't have any complaints but I would tell them if I had." A

visiting relative told us, "We've no reason to complain in recent weeks." Although there were policies in place to manage and responded to complaints, complaints were not appropriately recorded or maintained. We spoke with the acting manager and asked to look at the homes complaints records. They told us there were no record systems in place and they were unable to confirm if complaints had been received and managed appropriately by the provider. This required improvement.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us of the recent instability in staffing and leadership at the home and how this had an impact on the care provided. This supported the findings at our inspection. Effective systems were not in place, or operated in a way that monitored the quality and safety of the service. Action was not taken to address any risks identified or make improvements to the safety and quality of the service.

Some people commented that the care and support had improved since November 2016 and others felt there had been no significant changes. Comments included, "I believe there have been improvements recently", "The best thing here is we are contented and have peace of mind about our loved ones care and safety here when we leave", and "The acting manager is ok, I think she is a listener. Not much has changed, most things here are fine."

There was a registered manager in post at the time of our inspection; however they were not present at the service. There was an acting manager in post and they were becoming familiar with the service. Since their acting position within the home in November 2016 notifications were submitted to the CQC as required. We saw the acting manager spent time with people using the service and staff we spoke with told us they felt supported by the acting manager. One staff member said, "The managers are lovely and very supportive." Another staff member commented, "I think the leadership is good, I can go to them at any time." However despite some positive comments we found there were significant shortfalls in the way the service had been managed, and in oversight by the provider.

Effective systems to assess and monitor the quality of the service, and take action to improve the quality and safety of the service were not in place. The acting manager told us there was no record of quality assurance checks or monitoring being conducted in the home prior to their arrival in November 2016. Medicines audits had not been effective in identifying unsafe medicines management. We saw that a medicines audit was conducted on the 13 January 2017 and had identified issues including the use of a wrong medicine code. We saw an action plan was implemented to address this. However prior to the acting manager being in place, medicines audits had not been conducted since July 2016. The July 2016 audit had identified issues with the safe medicines management at the home; however no actions were taken to address the concerns. We also noted copies of monthly medication audits conducted by the registered manager for the months of January, February, March, April, May and June 2016 did not match the significant concerns we identified within peoples medicines records as referred to earlier in the safe section of this report.

Where audits were carried out, insufficient action was taken to improve the safety and quality of the care for people at the service. We noted that a health and safety audit was conducted by the registered manager in January 2016 and identified that fire drills were to be carried out within the home and recorded. However a further health and safety audit conducted by the registered manager in April 2016 again recorded fire drills were to be carried out and recorded but no action had been taken to implement fire drills between January and April 2016. This posed a risk to the safety of people.

We noted there were audit tools in place to conduct night care audits; however we saw these had not been

completed at all. Accidents and Incident audits were last completed by the registered manager in July 2016 and recorded that two incidents involving two people using the service were identified. However accident and incident records showed that a further two accidents and incidents involving people using the service occurred in the month of July 2016 and did not get identified or form part of the audit record. Therefore risks to people's health and welfare were not identified and improvements were not made.

Kitchen audits were last completed by the registered manager in July 2016 and weekly fire alarm testing had not been carried out by the registered manager since the 1 December 2016. There were no records of maintenance work carried out at the home in place in order to monitor the safety of the environment and equipment.

None of the significant shortfalls in care plan and risk assessment documentation had been identified by the provider's quality monitoring systems. Therefore action had not been taken in order to make improvements and reduce the risks to people's safety.

People and their relative's views were considered through the provider's satisfaction surveys that were last conducted in June 2016. We saw that the overall feedback was positive; however four people commented on the lack of activities within the home and one relative commented that they did not know about the provider's complaints policy. Although the provider had sought feedback, the acting manager confirmed that there was no action plan in place or records to show that people's comments or requests for service improvements had been addressed. We identified activities required improvement at this inspection.

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

The provider's auditor advised us that they had recently started to conducted monthly medicines audits to ensure safe practice and we saw an audit had been conducted on the13 January 2017. We noted that since December 2016 medicines refrigeration temperatures were recorded on a daily basis to ensure medicines were fit for use. We saw that from December 2016 room temperature were monitored and recorded on a daily basis showing the temperature of the room to be below 25c which is safe to ensure medicines are fit for use.

As a result of concerning information about this home, the local authority and other healthcare professionals had carried out reviews of people's care. Following the inspection the provider told us they were in the process of reviewing their systems for monitoring the quality and safety of the service. However we could not check on the progress with this at the time of inspection and will continue to monitor the arrangements in place.

When reviewing records and speaking with people in the course of this inspection we identified that the provider had failed to notify the CQC of incidents in order for the CQC to monitor the safety and quality of the service provided prior to November 2016. A notification is information about important events which the provider is required by law to send us. For example notifying us of an injury to someone using the service.

These issues are in breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

When reviewing records and speaking with people in the course of this inspection we identified that the provider had failed to notify the CQC of the death of people using the service prior to November 2016. A notification is information about important events which the provider is required by law to send us. For

example notifying us when someone using the service has died.

These issues are in breach of Regulation 16 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There were some systems in place which allowed staff lines of communication within the home. Daily staff handover meetings were held which provided staff with the opportunity to discuss people's daily needs. Records showed that team meetings were also held, however we saw that these were not regular and the last staff meeting conducted was in September 2016. Minutes of the meeting held in May 2016 included health and safety, staff training and resident's needs. There were no minutes documented for the meetings held in August and September 2016. The provider therefore failed to maintain good communication and oversight necessary in relation to the management of staff and safe care delivery. This required improvement.

There were also some systems in place to seek the views of people using the service through resident meetings held. However people we spoke with could not comment on the frequency of these meetings or recall when they were last held. Records we looked at showed meetings were held in July, September and November 2016. Items discussed included activities provided within the home, staff photographs, menus and staffing. We noted that there was a request for cooked breakfasts on Fridays. We spoke with the acting manager who told us that cooked breakfasts were available at people's requests but people chose to have porridge or cereal. The acting manager confirmed that there were no action plans or records in place to show people's feedback had been consistently addressed. This required improvement.

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 16 Registration Regulations 2009 Notification of death of a person who uses services We identified that the provider had failed to notify the CQC of the death of people using the service prior to November 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We identified that the provider had failed to notify the CQC of incidents in order for the CQC to monitor the safety and quality of the service provided prior to November 2016.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered, managed and stored safely. Risks to people's physical and mental health needs were not assessed, monitored and reviewed to ensure risks were managed. People's care and support needs were not always reviewed in response to changes in people's identified needs. Accidents and incidents were not recorded and acted on appropriately.

The enforcement action we took:

An Urgent Notice to Impose Conditions was served on 26 January 2017. The provider is required to send us information on a monthly basis to evidence the safe management of medicines, risks to people in relation to their care plans and records of care delivery, safe staff recruitment records and action plans resulting from audits conducted of staff training. The registered provider must not admit any new service users to Rosecroft Residential Care Home without written agreement from the CQC.

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 Safeguarding systems and processes had not been operated effectively to protect people from abuse or harm.

The enforcement action we took:

An Urgent Notice to Impose Conditions was served on 26 January 2017. The provider is required to send us information on a monthly basis to evidence action plans resulting from audits conducted within the service of the training of all staff on safeguarding adults.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no records of maintenance checks or repairs in place to monitor the safety of the environment and equipment. Effective systems to assess and monitor the quality of the service, and take action to improve the quality and safety of the service were not in place. Where audits were carried out, insufficient action was taken to improve the safety and quality of the care for people at the service. Although the provider had sought feedback from people there were no action plans in place to show that people's comments or requests for service improvements had been addressed.

The enforcement action we took:

An Urgent Notice to Impose Conditions was served on 26 January 2017. The provider is required to send us information on a monthly basis to evidence the systems in place are effective in monitoring and assessing the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment practices in place were not robust and appropriate recruitment checks were not always conducted before staff started work to ensure applicants were suitable to be employed in a social care setting.

The enforcement action we took:

An Urgent Notice to Impose Conditions was served on 26 January 2017. The provider is required to send us information on a monthly basis to evidence the systems in place to ensure staff are recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, supervision and appraisal to enable them to carry out their duties and meet people's needs. Not all staff had received training in order to meet people's needs.

The enforcement action we took:

An Warning Notice was served on 31 January 2017. The provider is required to become compliant with Regulation 18, section (2) (a), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 20 March 2017.