Rose Cottage RCH Ltd

Rose Cottage

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rose Cottage is a residential care home providing personal care for up to 16 people some of whom may be living with dementia or have physical disabilities. At the time of our inspection there were 14 people using the service. Accommodation is provided over two floors with stair lift access to the first floor.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Some areas of the home were not clean or well maintained and infection control was not well managed.

Medicines were not managed safely. There were not enough staff to meet people's needs and keep them safe. We were not assured staff had received the training they needed for their roles. Recruitment processes were not thorough. People's dignity was not always maintained and they were not always treated with respect. People's care records were not always accurate and fully reflective of people's needs.

There was a lack of consistent and effective leadership and quality assurance systems were not effective in identifying and addressing issues.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Safeguarding processes were followed. Accident and incident reporting and analysis had improved. People received a choice of meals, snacks and drinks and the dining experience had improved. There were some activities taking place.

People and relatives were generally positive about the service. Staff were described as kind and caring. People had access to healthcare services.

The provider took action during the inspection to address some of the issues we raised.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 29 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks. This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rose Cottage on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, recruitment, dignity and respect and good governance at this inspection.

We made referrals to the local authority safeguarding team regarding concerns we identified during the inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rose Cottage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Rose Cottage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rose Cottage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for eight weeks.

Notice of inspection

This inspection was unannounced. Inspection activity started on 31 May 2023 and ended on 20 June 2023. We visited the service on 31 May and 7 June 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning and safeguarding teams. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 6 people who used the service and 5 relatives about their experience of the care provided. We spoke with 4 staff including the manager and care workers.

We reviewed a range of records. This included 7 people's care records and 7 people's medicine records. We looked at 2 staff recruitment files. A variety of records relating to the management of the service were reviewed.

We provided feedback to the manager and nominated individual following both days when we visited on site. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider did not have systems in place to ensure medicine management was safe. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not managed safely. Room temperatures where medicines were stored exceeded the safe range for 3 consecutive days with no evidence of action taken.
- Medicine administration records (MAR) were not well completed which meant we could not be sure people were receiving their medicines as prescribed. For example, one person was prescribed eye drops 6 times a day, the MAR showed it had been given 5 times a day. Another person was prescribed pain relief, which had been out of stock since 20 May 2023.
- Transdermal patches were not rotated in line with the manufacturer's instructions. One person's daily patch had been applied 12 times in the same location over a period of 20 days. The instructions stated the patch must not be applied in the same location twice in 14 days. This had been raised at the previous inspection.
- Topical cream charts had been printed but were not in use. There was no guidance for staff about where to apply creams or how often and no signatures to show creams had been administered.
- There were no protocols in place for 'as required' meds. Times were not recorded for time specific medicines such as paracetamol so we could not be assured there were adequate gaps between doses. This had been raised at the previous inspection.
- Medicine audits were completed regularly but had not identified the issues we found.

We found no evidence that people had been harmed however, systems were not in place to ensure medicine management was safe. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider did not have systems in place to ensure risks to people were assessed and managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks to people were not always fully assessed or acted on. Moving and handling practices were not safe. People who were unsteady on their feet were not supported safely by staff who we saw leading and pulling them along by the hand. We saw staff assisting people out of chairs by pulling on the person's hands.
● Environmental risks were identified. This included an unrestricted window in an occupied room which was accessible and opened fully onto a conservatory roof. The provider assured us this had been fixed immediately when we raised it on the first day, yet the window still opened fully when we returned on the second day posing a significant risk to people.
● There were no systems in place to ensure bed rails were safe and secure. The rails had been removed from some beds but the screws attaching the bed rails had been left sticking out. One person's mattress was too big for the divan bed base.
● Two people had sensor mats on their chairs during the day when they were in communal areas due to the high risk of falls. These mats were not linked to the call bell system. This presented a potential risk as we were not assured, if there were only two staff on duty and they were upstairs, they would be able hear the mat sounding when the person stood up.
● Fire escape routes were not always kept clear which presented a potential risk if people needed to be evacuated in an emergency.

We found no evidence that people had been harmed. However, risks to people were not always assessed and managed which placed them at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed some actions had and were being taken to address the risks.

Preventing and controlling infection

At our last inspection the provider did not have systems in place to ensure risks associated with infection prevention and control were assessed and managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Following the last inspection domestic staff hours had increased and cleaning schedules were put in place. However, we found some areas of the home were not clean. Three bedrooms had strong malodours. The commode in another room was full of urine and a towel and underwear had been left on the floor. The shower mat in the upstairs bathroom was heavily stained.
● We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. Hand gel was available however, hand washing facilities were limited. Soap dispensers in the bathroom and toilet were empty. The majority of bedrooms had no dispensed soap. The provider told us people's wash bowls were being used to transport dirty laundry.

We found risks associated with infection prevention and control was not always assessed and managed which placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed actions had and were being taken to address the risks.

● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider stated visiting was unrestricted apart from protected mealtimes and visiting late into the evening. Most relatives we spoke with were happy with the visiting arrangements, however one relative raised concerns about restrictions placed on their visits. We shared these with the provider and the local authority safeguarding team. Following the inspection the provider confirmed they had met with the relative and addressed their concerns.

Staffing and recruitment

At our last inspection the provider did not always have enough staff on duty to keep people safe. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not enough staff to meet people's needs and keep them safe.
● On the first day of inspection the inspector had to support a person who was walking around and at risk of falling. No staff were present. Earlier in the day the person had been sitting on a sensor mat but this was not in place later. The inspector alerted staff via the call bell.
● Following the last inspection, the provider had increased the number of staff on duty in the evening. A dependency tool was used to calculate staffing levels. The tool identified 4 people with high dependency needs. However, staff told us and care records showed an additional 2 people who required 2 staff to assist them. This made it difficult for the 2 or 3 staff on duty to monitor all three communal areas and provide support to people.
● Care staff on days and nights had to do the laundry. Care staff at night also had cleaning tasks and vegetable preparation to complete as well as hourly checks of people in the home.
● A relative said, "In an evening you can be waiting ages before you get a free member of staff to help. I've even stepped in and helped because they are so short."

There were not enough staff to meet people's needs and keep them safe. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not have safe recruitment processes or systems in place. We reviewed 2 staff recruitment files which contained multiple gaps in application forms, applicants' employment histories and there was a lack of proof of identity.

We found people were placed at risk as recruitment processes were not safe. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Monthly accidents and incident analysis had improved. Trends and themes were considered and actions recorded.

Systems and processes to safeguard people from the risk of abuse

- Systems were in place to protect people from the risk of abuse and harm.
- The majority of staff had received safeguarding training and the manager confirmed further updates were scheduled.
- Records showed safeguarding incidents had been referred to the local authority safeguarding team and notified to CQC.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- Staff had not received the training they required to fulfil their roles.
- The manager provided a training plan dated 2023 which showed planned dates for mandatory training. This identified gaps in training that had already taken place in 2023 which included medicines, fire safety, moving and handling and safeguarding. We requested information to show previous training dates. This was not received.
- Some staff supervisions had taken place in 2023.

The provider had failed to ensure staff received the training they required to fulfil their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure people's nutritional and hydration needs were met. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

- Most people were provided with sufficient amounts of food and drink. We observed lunch on both days. A large table was set up in the conservatory and people were encouraged to sit together and have lunch. The food looked appetising and everyone was given a choice about what they wanted to eat and drink and how much. People said they enjoyed the food.
- However, on the second day of the inspection we observed one person was not provided with sufficient food or drink and on reviewing their food and fluid intake charts this showed they were not in receipt of sufficient amounts regularly. We raised this with the manager who assured us they would take action.
- People's weights were monitored and records showed actions taken in response to weight loss.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● People's capacity to consent to their care and treatment and live at the home was assessed. Where people had capacity consent was recorded.
● Where people's capacity to make a particular decision was uncertain, capacity assessments and best interest decisions had not always been completed. For example, there was no consent recorded for any people regarding the use of CCTV. Following the inspection the provider sent evidence of consent to CCTV usage for 7 people. There was no consent or capacity assessment for one person who had a sensor mat in their chair.
● The manager confirmed, although applications for DOLS had been made, there were no authorisations in place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to admission into the home. However, there was a delay in creating a care plan. One person who had been living in the home for a month did not have a full care plan in place and there was minimal information for staff about how to meet the person's needs.
Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Care records showed the involvement of healthcare professionals such as community nurses and GPs.
● Some people did not have care plans in place for oral or foot care. One person had no oral care plan or evidence to show oral care had been given. Other people did not to have oral hygiene equipment. Two people had very long toenails and no foot care plans. This was addressed for one person when we raised it.

Adapting service, design, decoration to meet people's needs
● The environment was not well maintained and did not promote independence for people living with dementia. Bedroom doors were all the same colour and some had no name or photograph to help people find their rooms. The manager advised dementia friendly signage had been ordered and decorators were in the home on the second day of the inspection.
● There were some pictorial signs to indicate bathrooms and toilets. However, one bath and one toilet were out of use reducing the access to baths and toilets downstairs. Following the inspection the provider informed us these had both been repaired and a full refurbishment programme had been completed

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We identified concerns relating to people's choice, privacy and dignity which had not been addressed by staff, management or the provider. Relatives told us of ongoing issues with the laundry service including clothes going missing and other people's clothing appearing in their family member's room despite being labelled. There was no screening curtain in a room shared by two people.

● People did not have access to a call bell and sensor mats were being used for the majority of people. This had not been recognised as a restrictive practice. One person told us they had to bang on the wall or shout for assistance if they required help from staff. The provider told us the person had capacity and this was their choice. There was no evidence to show any other options had been considered.

We found people were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Overall people and relatives were satisfied with the care provided. One person said, "I like living here. Staff are nice." Staff knew people well and we saw some kind and caring interactions and some activities taking place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found systems and processes were either not in place or robust enough to demonstrate good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Significant shortfalls were identified at this inspection, some of which were similar to the issues raised at the previous inspection. There were breaches in relation to safe care and treatment, staffing, recruitment and dignity and respect.

● There was a lack of effective leadership and management. The registered manager left after the last inspection. The current manager had been in post 8 weeks.

● Quality assurance systems were not effective in identifying and addressing issues and risks we found at the inspection. Some quality audits were in place, however, where issues were identified, there was no

evidence to show these had been addressed. For example, an external audit carried out in March 2023 identified shortfalls in consent, medicines and recruitment similar to those we found at this inspection. The provider's improvement plan did not cover all the issues we found and showed limited progress in implementing improvements.

● Systems for managing risks to people's health and safety were ineffective. Where shortfalls and concerns had been raised on the first day of inspection, not all of the issues were rectified despite the provider confirming they had been.

● There was a lack of oversight and monitoring in relation to the completion of daily records, food and fluid charts and hourly night safety checks. We found multiple examples where there were gaps in documents and missing checks.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and staff spoke positively about the manager and the improvements they had made in the short time they had been at the home. They said the manager was approachable and acted on matters they raised.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibilities in relation to the duty of candour and communication with people when things went wrong. They knew how to share information with relevant parties, when necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider sought feedback from people and relatives through surveys. A summary of the most recent survey in November 2022 showed actions taken in response to suggestions made.

● Resident meetings had been held in January and March 2023 and had resulted in changes to the food and menus in response to people's feedback. The provider had also arranged for people to visit a nearby hairdresser as some people had said they missed going to a salon.

● Regular staff meetings were held where improvements were discussed and best practice shared.

● The provider worked in partnership with other agencies to ensure people's needs were met.