Gradestone Limited

Roseworth Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Roseworth Lodge Care Home is a care home providing personal and nursing care for up to 48 people. The service provides support to older people. At the time of our inspection there were 47 people using the service.

People's experience of using this service and what we found
Guidance from external health care professionals was not always followed. Equipment to support people was not always used and care plans did not outline how it was to be used. Monitoring of important clinical information was not always recorded.

The provider did not ensure people had a safe environment. Environmental hazards had not always been identified or risk assessed to reduce the danger to people. Infection prevention and control (IPC) was not always safely managed. The home was not well maintained.

Effective plans to keep people safe in the event of a fire were not in place. Personal Emergency Evacuation Plans (PEEPs) were not always in place. Fire drills had not regularly taken place and staff were not confident in the use of the evacuation equipment. People were not always treated with dignity and respect.

The provider did not have effective quality assurance systems in place. The provider failed to ensure the quality and safety of the service was monitored effectively. People's care and support records were not accurate and complete and were not always held securely.

Systems were in place to investigate safeguarding matters. Staff had completed safeguarding training. The provider was taking action to improve the management of medicines and was working with the local authority.

A safe recruitment procedure was in place. Staffing levels were not always appropriate to meeting people's needs. We have made a recommendation about this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 good (published 28 April 2021).

Why we inspected

We received concerns in relation to people's catheter and diabetes care and support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Due to the shortfalls found during the inspection the provider was requested to produce an action plan detailing what action and by when, they would address the issues identified.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, risk monitoring and management, dignity and respect and the governance of the home.

Follow up
We have already requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 of 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Roseworth Lodge Care Home

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 Care Act 2014.

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
2 inspectors carried out this inspection.

Service and service type
Roseworth Lodge Care Home 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. Roseworth Lodge Care Home is a care home with 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 a registered manager in post. The registered manager was currently

managing another of the provider's services. An acting manager was responsible for the management of the service.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 2 November 2022 and ended on 15 November 2022. We visited the service on 2 and 4 November 2022.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 visiting relatives and 10 people about their experience of the care provided. We spoke with 12 members of staff including the acting manager, the administrator, a quality assurance officer, a nurse, 2 seniors, a cook, 4 care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at the care records of 14 people, a sample of medicines records and other records related to the management of the home.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people were not always identified and mitigated. Risks associated with certain conditions had not been managed to ensure people remained safe.
• Monitoring of important clinical information was not always recorded. Recording of blood glucose levels and monitoring of input and output relating to catheter care were not fully completed placing people at risk of harm.
• Guidance from external health care professionals was not always followed. Equipment to support people was not always used and care plans did not outline clear instructions for usage of this equipment. Information to support people to remain safe with their dietary needs had not been passed to kitchen staff.
• Effective plans to keep people safe in the event of a fire were not in place. Personal Emergency Evacuation Plans (PEEPs) were not always in place. PEEPs held in a bag to be taken by staff in the event of an emergency contained information about people no longer living at the home. Fire drills had not regularly taken place and staff were not confident in the use of evacuation equipment.
• The provider did not ensure people had a safe environment. Environmental risks had not always been recognised and reduced. Items which posed a hazard to people were not stored appropriately. Bedrail checks had not been conducted and therefore placed people at risk of harm.

The provider failed to ensure care and treatment was provided in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider created an action plan detailing how they would address the shortfalls identified and were working to complete this.

Preventing and controlling infection
• Infection prevention and control (IPC) was not always safely managed. Donning and doffing stations were not clearly defined and did not always contain the required PPE. Used PPE was found in non-clinical bins in people's rooms.
• Cleaning processes were not effective. Cleaning rotas were marked as completed; however some areas of the home were not clean and wheelchairs and commodes were dirty and rusty.
• The home was not well maintained. Handrails were chipped and in areas bare wood was exposed which made it difficult to clean. In bathrooms and showers, pipework was exposed, and we found holes in walls and doors. Some chairs, mattresses and bedrails were worn and ripped.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure infection control procedures were effective. This was a breach of regulation 12 (Safe Care

and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider created an action plan detailing how they would address the shortfalls identified and were working to complete this.

Staffing and recruitment
• A safe recruitment procedure was in place. The provider conducted checks including Disclosure and Barring Service checks and obtained references before new staff were employed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Staffing levels were not always appropriate to meet people's care needs. On 3 occasions we had to find staff to support people and we observed people unattended without staff present. The acting manager told us staffing levels were determined by using a dependency tool.

We recommend the provider reviews their staffing dependency tool to ensure it is effective in line with best practice 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• The service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely
• The provider had taken action to improve the management of medicines. Following previous concerns, the provider was working with the local authority to address issues. They had started to make changes and recognised further improvements were required.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems in place to investigate safeguarding concerns. Staff had completed safeguarding adults training. Safeguarding concerns were investigated and reported to the appropriate authorities.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The provider and the management team did not ensure the home was meeting all of the regulations. During the inspection we found serious concerns relating to people's safe care and treatment, the management of risk, infection control and quality assurance monitoring.
• The provider did not ensure it had oversight of the home. Quality assurance processes were not in place or were ineffective.
• The home lacked leadership. Staff did not demonstrate accountability or responsibility regarding the issues identified.
• People's care and support records were not always completed. People's clinical records were not reviewed which placed people at risk of harm. None of the management team had highlighted this as a concern.
• People's clinical records were not held securely. The home did not have any systems in place for the storage of important documentation and staff were unable to find records requested.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider created an action plan detailing how they would address the shortfalls identified and were working to complete this.

• The provider understood their legal requirement to notify the CQC of certain accidents, incidents and events. The home had submitted the required statutory notifications to CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff did not support people in an inclusive manner. Staff did not recognise when people's care and treatment did not reflect their needs. People's dignity was not always respected.

The provider failed to ensure people were treated with dignity and respect. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to address the issues relating to people's dignity and respect.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider did not regularly obtain feedback from people and their relatives. The provider had started to address this.
• Staff had opportunities to express their opinions in supervisions.

Working in partnership with others
• The provider worked with external healthcare professionals, however, information was not always included in care plans and followed by staff.
• The management team were engaging with the local authority to address issues relating to the management of medicine.

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 provider understood their duty of candour responsibilities. The provider and management team acknowledged when things went wrong and gave a full explanation.
• The provider and the management team fully engaged with the inspection process.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure care and treatment was provided in a safe way. Infection prevention and control (IPC) was not always safely managed. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the quality and safety of the service. Regulation 17