Care Quality Commission

M & C Taylforth Properties Ltd

Rossendale Nursing 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
Rossendale Nursing Home is a residential care home providing personal and nursing care to 18 people aged 65 and over at the time of the inspection. The service can support up to 21 people in premises made from two adapted town-houses close to the centre of St Annes.

People's experience of using this service and what we found
People were at risk of harm because the provider had not ensured risks were assessed and managed effectively. Medicines were not managed safely and properly. We found some shortfalls in relation to infection prevention and control. There were sufficient numbers of staff deployed to meet people's needs, but the service relied heavily on agency staff, which impacted the consistency of care for people living at the home. We have made a recommendation about ensuring recruitment records are retained in line with legal requirements.

The provider has repeatedly failed to assess, monitor and improve the quality of the service. This left people at risk of avoidable harm.

We saw some positive interactions between staff and people who lived at the home. Staff spoke positively about their work and the support they received from the registered manager.

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 23 December 2020). The service was rated requires improvement for the last three consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
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 inspection was prompted in part due to concerns received about pressure area care, medicines management, safeguarding concerns, falls and risks related to the management of swallowing difficulties. A decision was made for us to inspect and examine those risks. As a result, we carried out a focussed

inspection to review the key questions of safe and well-led only.

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

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

Since the inspection, the risk has been mitigated because commissioners terminated their contract with the service. All service users were moved to alternative placements and no one is currently living at the home.

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

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines management, management of risk, recruitment processes and good governance.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care Quality Commission

Rossendale Nursing 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
The inspection was carried out by two inspection managers on the first day and one inspector and a specialist professional advisor in medicines management on the second day. One inspector worked remotely, reviewing care records.

Service and service type
Rossendale Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. One of the registered managers was also the provider. The other registered manager had left their post at the time of the inspection.

Notice of inspection
This inspection was unannounced on the first day. The second day of the inspection was announced.

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. The provider was not asked to complete a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight members of staff including the provider, clinical lead, care workers, domestic staff. We carried out observations in communal areas to see how staff interacted with people and checked the premises to ensure they were clean, hygienic and a safe place for people to live.

We reviewed a range of records. This included multiple people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records related to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, insurance details and asked the provider for details about people's care needs.

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 now deteriorated 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

At the last inspection, the provider had failed to robustly assess and mitigate risks related to the health, safety and welfare of people who used the service. This was a breach of regulation 17 (Good governance) 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.

● Risks to people's health and safety were not managed effectively. For example, we saw people had been assessed as being at risk of pressure sores, swallowing difficulties, nutritional risk and falls. There was a lack of evidence that risks were managed safely, including prompt referrals to healthcare professionals for support and guidance. Records of actions taken by staff to manage risk did not consistently evidence risk was managed safely.
● Risk assessments and care plans did not provide sufficient information to manage risks to people safely. At times the information recorded was contradictory and confusing. We spoke with some regular staff at the home who were able to describe how they supported people safely. However, the service relied heavily on agency staff, who were not familiar with people, and required accurate information to support people safely.
● Environmental risks had not been identified and addressed. During the inspection we noted concerns in relation to health and safety, fire safety and the maintenance of the premises. For example, holes in compartmentation which affected fire safety, fire doors not closing properly, a hole in a wall in the lounge which was mouldy and a bathroom floor which was in a poor state of repair. The provider's systems had failed to identify these concerns and so no plan was in place to manage them effectively.
● The provider had failed to ensure lessons were learned from adverse events, including issues raised at previous inspections. There were recurring themes in relation to the management of risk for people. For example, risks had been highlighted previously around choking risks and falls where people had suffered harm. We were not assured the provider had learned from events and embedded changes in practice to try to reduce the risk of recurrence.

These failings by the provider placed people at risk of harm and demonstrated a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found systems were either not in place or robust enough to demonstrate medicines were managed safely and properly. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found not enough improvement had been made and the provider remained in breach of regulation 12. People were at risk of harm due to unsafe management of medicines.

● The provider had failed to ensure the safe and proper management of medicines. During the inspection, we observed staff administering medicines did not follow safe practices. We found medicines were out of stock for some people, meaning they were unavailable if and when they needed them. This placed people at risk of avoidable harm. We found medicines in storage which were beyond their expiry date and may not have been effective.
● Medicines storage arrangements were not safe. We found controlled drugs were not stored in line with legal requirements. Controlled drugs are medicines which are subject to additional controls because they may be misused. We found records of temperature checks on the medicines fridge were consistently recorded as above the maximum temperature they should be. This meant medicines stored in the fridge, including insulin, may not have been stored at temperatures in line with the manufacturer's instructions and clinical guidance. This can lead to medicines becoming ineffective and leaves people at risk of harm.
● We found the management of covert medicines was not always safe. Covert administration is when medicines are administered in a disguised format. We found guidance and safety advice on how to administer medicines covertly was not in place for each person who required them. We found equipment used to crush medicines in preparation for administration was heavily contaminated with other medicines. This presented a risk of cross contamination and placed people at risk of receiving medicines they had not been prescribed and to which they could potentially have an adverse reaction.

The provider had failed to ensure the safe and proper management of medicines. This placed people at risk of harm and was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The stability of the service had been impacted negatively due to difficulties in recruiting staff, including nurses. The service relied heavily on agency workers which meant staff did not always know the people they were caring for, their needs and their preferences. At the time of the inspection, the service was being supported by additional nursing staff who had been put in place by the local authority to try to help support clinical governance and address issues with medicines.
● The provider had systems to follow to ensure staff were recruited safely. This included criminal records checks and checks on conduct in previous roles, related to health or social care. However, the provider failed to ensure they retained records required by law for each member of staff.

This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider was unable to produce records in line with legal requirements.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected against the risk of abuse or improper treatment. The inspection was triggered due to a significant amount of safeguarding concerns and we were not assured that people were always protected from the risk of abuse or improper treatment.

● Staff we spoke with, who were employed by the provider, knew how to escalate safeguarding concerns. We witnessed some positive interactions during our inspection. However, the concerns raised around risk management highlighted the provider's systems had not effectively protected people.

Preventing and controlling infection

● We were not assured that the provider was meeting shielding and social distancing rules. The provider was supporting people living with dementia who did not always understand the need for social distancing. The registered manager was aware of good practice guidance related to infection prevention and control.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the home had not been properly maintained which meant they could not be thoroughly cleaned and disinfected.

● We were somewhat assured that the provider was using PPE effectively and safely. We observed staff mainly used PPE appropriately. However, we also observed staff not following best practice in relation to PPE used. We fed this back to the registered manager.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured that the provider was preventing visitors from catching and spreading infections.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

At our last inspection the provider had failed to maintain effective records and documented evidence of treatment oversight. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had not been made and the provider was still in breach of regulation 17. This is a continuing breach. The provider has been in breach of regulation 17 for the last three inspections.

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

- The level of person-centred care people received was inconsistent. We saw some care plans contained some good person-centred information. However, other care plans we reviewed were not accurate and up to date, and so did not reflect people's current needs which placed them at risk of avoidable harm. The service relied heavily on agency staff. Records were not of good enough quality to guide staff on how to meet people's needs safely in a person-centred way.

The provider's failure to maintain accurate contemporaneous records in respect of each service user and their care and treatment was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider's systems to assess, monitor and improve the quality of the service had failed to identify and address the issues highlighted in this report. This left people at risk of harm from fire safety, to choking, from the risk of developing pressure sores to receiving medicines in a way that was unsafe.
- Learning and improvements had not been embedded to ensure safety, consistency and quality of care. The provider had been supported for a significant period of time through a quality improvement process with local system partners. However, the shortfalls in practice and breaches of legal requirements referred to in this report demonstrated people's care had not improved and been sustained as a result of the process.

The provider's repeated failure to assess, monitor and improve the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at serious risk of harm because the provider had not operated effectively systems designed to keep

them safe.

● Staff were committed to providing quality person-centred care. They spoke positively about the service and the provider. We observed some positive interactions between people and staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider engaged with people, relatives and staff. We saw minutes of meetings whish showed people who lived at the home and staff were consulted regularly on a variety of topics. Staff had engaged with people's relatives during the pandemic.

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 had a policy and procedure to guide staff on their responsibilities and action they should take when something went wrong.