Rockliffe Court Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rockliffe Court Limited is a residential care home providing personal care to 33 people at the time of inspection. The service can support up to 35 people, some of whom may be living with dementia or have a sensory impairment.

People's experience of using this service and what we found
People at Rockcliffe Court Limited did not receive a safe, responsive or well-led service.

At the last inspection, we found concerns relating to the safety and cleanliness of the premises, management of medicines and quality assurance systems were not effective.

At this inspection we found minimal changes had been made to the quality assurance systems and necessary improvements to the service had not taken place or been sustained. Risks to people were not always identified and safely managed. Accidents and incidents were not effectively monitored to consider lessons learnt and reduce the risk to people. There were several incidents that should have been notified to the local safeguarding team and to the Care Quality Commission (CQC), but this had not been done.

There were concerns relating to people's safety which included poor oversight of fire safety issues, a lack of training and guidance for staff on how to support people in the event of a fire which put people at significant risk of harm.

The service did not have sufficient infection prevention measures in places. Areas of the premises were unclean and furniture was worn and in need of replacement.

Medicines were not managed safely. Staff did not always have guidance to ensure they administered 'as and when' required medicines to people safely. Medicines were not always stored safely and stock levels of controlled medicines were not accurately recorded.

There was little provision for activities within the home and there was no clear record of how people were supported to interact and engage in activities. We have made a recommendation about this.

End of life care plans lacked detail, they did not explore peoples wishes or needs in their last days of life and did not consider pain relief and families wishes. We have made a recommendation about this.

Systems were in place to recruit staff safely. However these were not always completed effectively. The provider failed to complete inductions with newly recruited staff to ensure they were fully prepared to support people using the service in a safe and effective manner. We have made a recommendation about the induction of staff.

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. However, despite this staff were kind, caring and respectful to people using the service.

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 10 July 2019) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations relating to the premises safety, governance systems and managing risks. The service has been rated as requires improvement for the last two inspections and has now been rated inadequate.

Why we inspected
This was a planned inspection based on the previous rating.

We carried out a focused inspection to review the key questions Safe, Responsive and Well- Led.

We have found evidence that the provider needs to make improvements. Please see Safe, 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.

You can read the report from our last comprehensive inspection, by selecting the all reports link for Rockliffe Court Limited on our website 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 exceptional circumstances arising as a result of 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 fire safety and managing risks, management of medicines, staff training and support, failing to operate effective monitoring systems to improve the quality and safety of the service, poor record keeping, notification of incidents and safeguarding people from risk of harm or abuse.

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 request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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, 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.

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 responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Rockliffe Court limited

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Rockcliffe Court 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 a manager 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.

This inspection was unannounced. The inspection was announced via telephone before we entered the premises.

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 requested an update from the provider on improvements made since the last inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service, two relatives, six care staff, one team leader, two kitchen staff, and the registered manager who was also the provider of the service.

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

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and information relating to fire safety. We reported our concerns regarding fire safety to Humberside Fire and Rescue Service and we contacted the local authority with our concerns.

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.

Systems and processes to safeguard people from the risk of abuse
• The provider did not always follow appropriate processes to safeguard people from the risk of harm.
• The provider had not reported incidents to the local authority safeguarding team or CQC.
• Some staff had not completed their safeguarding training.
• Staff were unsure how to refer incidents to the local authority safeguarding team. One member of staff said, "I just trust the senior or manager to do what they need to." When asked if they would contact the local authority themselves they stated they would not know how to and would have to ask someone how to do this.

A failure to ensure systems and processes were in place to protect people from abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

At our last inspection there were issues with the effective management of risk and safety. This was a breach of Regulation 12 (Safe care and treatment) 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.

• The provider had failed to fully risk assess people's needs in relation to fire safety.
• One person at the home smoked in their bedroom. The provider had not assessed the risks associated with this.
• Not all staff had completed fire safety training, fire drills or evacuation training. This meant they may not know how to support people in an emergency.
• Records relating to fire safety such as, evacuation plans and guidance for staff to follow in the event of an emergency were not up to date, nor had they been completed for all of the people who lived at the home.
• Some areas of the home had been left unlocked which posed a risk to people's safety. This included storage areas on the top floor.

We found no evidence that people had been harmed. However, people's safety was not always effectively

managed. 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.

Using medicines safely
• Medicines were not managed safely.
• Guidance for staff to safely and consistently administer medicines prescribed 'as and when required' (PRN) were not in place. This meant staff did not have any guidance to help them make decisions about when and how much medicine to give people.
• Staff did not ensure sufficient stocks of medicines were available within the service.
• The controlled drugs register was not completed accurately.
• The systems for storing lotions and creams in people's bedrooms were not in line with best practice guidance.
• One person was prescribed a medication patch to be changed every three days. Records showed this did not happen.

The failure to adequately manage robust medicine systems and practice was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection: Learning lessons when things go wrong

At our last inspection there were issues with cleanliness and safety in some parts of the environment. This was a breach of Regulation 15 (Premises and Equipment) 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 15.

• People were not protected from the risk of infection.
• The provider did not have robust cleaning schedules in place to ensure a safe and clean environment.
• There were no daily checks of the environment in place to ensure standards of cleanliness were maintained to a high standard. Satisfactory standards of hygiene had not been maintained. We found dirty beds, carpets and items of furniture in people's bedrooms. Bathrooms were unclean and there were malodours in some bedrooms.
• Armchairs continued to have breaks in the covering which meant they could not be cleaned effectively. Other worn items included a cushioned toilet back and a toilet seat frame where the legs had become rusty.
• Laundry tasks were not carried out in line with the provider's laundry policy and some laundry washing facilities were out of order. This meant there was an increased the risk of infection.

We found no evidence that people had been harmed. However, there continued to be risks relating to the safety and cleanliness of the environment. This placed people at risk of harm. This was a continued breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider had not considered staffing levels in line with people's needs.
• Staffing levels at night did not ensure that people were safe in the event of a fire emergency situation.
• The staff rota showed there had been occasions where staffing levels were low. This put people at increased risk of harm.
• An induction process for new staff was in place. However, this was not completed effectively, and some

staff had not completed their induction training. This put people at risk of receiving unsafe care and treatment from staff who may not understand their needs.

We recommend the provider ensures all staff compete a thorough induction prior to commencing in their role.

• Recruitment processes were in place.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

• Care plans for some people contained information that was not consistent with information in related risk assessments.
• Behaviour management plans did not provide enough detail to enable staff to support people's needs appropriately.
• Reviews carried out within the service did not always seek the views of people's relatives.
• End of life care plans lacked sufficient detail. They did not explore peoples wishes or needs in their last days of life and did not consider pain relief and families wishes.

We recommend the provider consider best practice guidance in relation to end of life care.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
The registered manager was aware of the AIS and provided adapted information if this was needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People did not always have access to a planned schedule of activities.
• There was no plan in place for the facilitation of activities. The registered manager told us that activities were regularly carried out within the home. However, activity records did not show this.
• The activities coordinator told us they found it difficult to arrange activities people liked and were willing to engage in especially people living with dementia.
• Although time was planned for activities within the service, this would often change due to insufficient staffing levels.

We recommend the provider review the provision of activities within the service and ensure staff are skilled to deliver these effectively to all service users.

Improving care quality in response to complaints or concerns

• There was a complaints procedure in place. However, this was not easily accessible for people or their relatives.

• One relative told us that they did not always feel their concerns or complaints were listened to and found it difficult at times to contact the registered manager to discuss further.

• Records relating to complaints were not always completed. For example, where issues had been raised by relatives, there were no records to support these or the actions taken to resolve the complaint.

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.

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

At the last inspection systems to assess and monitor the quality and safety of the service were incomplete, out of date or not effective. This was a continued 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.

• The registered manager did not understand quality performance, risk and regulatory requirements.
• The provider failed to demonstrate how they were working towards improving standards at the service. Our findings showed there had been a lack of improvement which had also placed people at significant risk of harm.
• Some quality assurance processes were operated, but they did not identify concerns we found on inspection. The lack of robust systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk of harm. For example, failing to ensure appropriate infection control processes were in place.
• Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.
• Staff files were not always accurately maintained, including missing records for staff interviews.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service and ensure compliance with the regulations. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Record keeping had not been properly monitored at the service and this impacted on the staff's ability to provide person-centred care. For example, behaviour plans were not detailed enough, and care plans did not always reflect people's needs.

• The registered manager had not effectively identified and managed risk therefore, people were placed at risk of avoidable harm.
• Serious shortfalls identified at this inspection had not been identified by the provider's quality assurance system.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service and ensure compliance with the regulations. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 not been responsive to issues and concerns raised in the last inspection.
• The provider had failed to notify the CQC of notifiable incidents that happened in the home. This included allegations of abuse and serious injuries.
• The outcome of complaints and investigations was inconsistent and did not demonstrate an open and transparent approach to investigating complaints.

This was a breach of Regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009. We did not proceed with enforcement action on this occasion.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Meetings were carried out with people using the service. However, their views and wishes were not always discussed.
• The registered manager advised relatives meetings had not taken place due to the current COVID-19 pandemic. However, one relative stated that they had never been invited to relatives' meetings or completed any questionnaires on the service.
• Staff meetings were carried out and staff told us they felt communication was good, and the registered manager was approachable.

Working in partnership with others
• A culture of high quality, person-centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this inspection.
• Further development of working in partnership with key organisations including the local authority safeguarding team and social services was required to ensure transparency and good outcomes for people.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess, monitor and reduce risks to peoples health and safety. Care plans and risk assessments were inconsistent, and not fully completed. Medicines were not managed safely. The provider had failed to ensure that robust systems were in place to manage and prevent the risk of infection. 12 (1) (2) (a) (b) (f) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were in place to protect people from abuse. Staff knowledge in relation to reporting concerns was poor. The provider had failed to report safeguarding incidents which had occurred at the service to the relevant authorities. 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not have robust schedules of maintenance in place to ensure a safe and clean environment. There was a failure to ensure that areas of the premises were maintained to a high standard. This included equipment and furnishings within the service. 15 (1) (a) (e) (2)

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of notifiable incidents that had occurred within the service. Registration regulation 18 (1) (2) (e)

The enforcement action we took:

We did not proceed with enforcement action on this occasion.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective governance systems to ensure the safety and quality of the service. Record keeping standards were poor. The provider failed to demonstrate how they were working towards improving standards at the service. Investigations and auditing of accidents and incidents was not robust. 17 (1) (2) (a) (b) (c) (e)

The enforcement action we took:

We issued a warning notice against the provider.