Banstead, Carshalton And District Housing Society

Roseland

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
Roselands is a residential care home providing personal care for up to 39 older people some of whom were living with dementia. The home is a large purpose-built care home run by Banstead, Carshalton and District Housing Society which is a Not for Profit Charitable Society. At the time of the inspection there were 21 people living at the service.

People's experience of using this service and what we found
People did not always receive care when they needed as there were not sufficient staff deployed at the service. Medicines were not always being managed in a safe way which put people at risk. The maintenance of the environment required improvement and equipment was not always fixed in a timely way.

People told us staff were kind and we did observe this however we found that systems were not in place to ensure that people were protected from the risk of abuse. Risks associated with people's care were not always being managed appropriately.

There were insufficient audits taking place to review the quality of care. People and staff did not feel there was a strong leadership presence in the service. Staff did not always feel supported or valued. Notifications were not always sent to the CQC when required and the service was not displaying their CQC rating appropriately.

The service was clean, and staff adhered to appropriate infection control measures. However, we have made a recommendation around staff ensuring that visitors attending the service during the COVID pandemic are asked for information on their health.

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 14 January 2020). 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. This included some continued breaches as well as new breaches of legal requirements since the last inspection.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 20 November 2019. Breaches of legal requirements were found.

We undertook this focused inspection to check they had followed their action plan and to confirm they were now meeting legal requirements. This report only covers our findings in relation to the Key Questions Safe

and Well Led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for this service has deteriorated to '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.

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

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.

Roseland

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
Our inspection was completed by two inspectors.

Service and service type
Roseland 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. The registered manager was on leave on the day of the inspection.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority which works with the service. We used this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with eight members of staff including the nominated individual. We reviewed a range of records including five people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the registered manager. We looked at policies and quality assurance records. We received feedback from one health care professional. We also spoke with four relatives.

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.

At our last inspection of the service, we found the provider had failed to ensure the environment including the furniture was well maintained and fit for purpose. Chairs that people were using were stained and broken and the carpets in the communal areas were stained and worn. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider still in breach of regulation 15.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The premises and equipment at the service was not always stored or maintained appropriately to help keep people safe. At the previous inspection we identified that chairs and carpeting in the communal areas were worn and stained. At this inspection this had not been addressed. The provider's infection control policy stated, "Any damaged equipment must be reported and repaired or condemned." However, the fabric on the chairs was more worn than at the time of our last inspection, in some cases, there were large holes in the base of the chairs that people were sat on. There was a risk that people may fall through the chair or become stuck.
- At the previous inspection one person's commode was worn, which meant unvarnished wood was exposed. This meant bacteria could permeate into the wood making it difficult to clean properly. On this inspection a commode similar to this was still being used. This was despite the infection control policy stating, "All furnishings and surfaces must be intact and washable."
- People told us they had to wait for equipment to be fixed at the service. One person told us they waited a long time for their bedside lamp to be fixed. They said, "These things shouldn't take so long and be so difficult to get sorted out." Another person said they had to ask many times to have a broken raised toilet seat fixed and had been frightened to sit down it as their, "Skin could get caught in the cracked plastic when I got up."
- There was a delay for equipment to be fixed or replaced when broken. Scales used to weigh people had been broken since August 2020. The provider and registered manager confirmed they had not taken sufficient action to address this and people were not being weighed. One member of staff said, "We tried to do monthly weights, but scales were broken."
- A member of staff said, "Equipment isn't being fixed very quickly. When something breaks you have to keep reminding them (the management team) to fix it." This included a grill in the kitchen that had been broken for 12 months which delayed certain types of food being prepared. Staff told us there was no plan for this to be fixed. A member of staff told us there was a sensor mat a person's room that had not been working for some time despite the person being assessed as at high risk of falls in their care plan.
- The walls and skirtings around the service were scuffed, chipped and wall paper torn. A light fitting had the plaster loose from around it. One relative said, "It's a bit scruffy." One member of staff said, "I think the home

could do with a lick of paint. The skirting boards are terrible." A communal bathroom that was accessible to people was being used to store chairs and broken pieces of equipment putting people at risk of injury if they entered the room.

● According to the service training data, 20 out of 49 members of staff had not received health and safety training and the remainder had not received the training for at least four years.

● After the inspection the nominated individual advised us that some of the damaged chairs that people were sat on had now been removed and plans were in place to replace the carpets.

As the premises and equipment was not maintained to a safe standard this is a continued breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were at risk as systems were not in place to ensure that they could alert staff when needed. There were people being cared for in their bedrooms and others cared for in bed. Staff told us that not all of these people were able to use their call bells due to their cognitive impairment. There was no risk assessment in their care plans to manage this. Staff told us there were no systems in place to record how often staff were checking on people in the absence of them being able to use their call bells. A member of staff said, "(person) has a call bell but she doesn't know how to use it. We have to keep going in to check on her. We don't use room charts to record this."

● Care plans did not always contain up to date and relevant information concerning the risks associated with people. This included skin integrity and risks around the management of mental health needs. Two people had been admitted to the service who had a mental health diagnosis since our last inspection. However there had also been no training for staff around these needs. One member of staff said, "I think we should have mental health training as a priority. We need to learn about mental health conditions."

● People's nutritional and hydration needs were not always being appropriately assessed, monitored or managed. Staff told us there were people that had not been eating and drinking well and had been placed on a food and fluid chart. We checked the food and fluid charts and found that the target and the totals amount had not been calculated. A member of staff said, "No one goes through food and fluid charts." One person that was on a fluid chart had been having frequent urine infections (UTIs). Dehydration can increase a person's risk of UTIs. One member of staff said, "We need to push fluids with her." However, given this risk, staff were still not adequately analysing how much fluid the person was having.

● The chef was not made aware when people were nutritionally at risk. A member of staff said, "Communication isn't good about people that need fortified meals which is poor."

● Another person had not been eating or drinking as much as they normally would. A member of staff told us, "We are really worried. We encourage her to eat and drink, but we don't record it. She likes to sleep so doesn't always get her meals." We checked the person's care plan and their nutritional risk assessment had not been updated since August 2020 and there was no mention of the person's recent reluctance to eat.

● One person was cared for in bed and they had an overall risk assessment that stated they were at medium risk of developing pressure sores. Although the person had a pressure mattress, staff were not repositioning the person. Their skin management assessment had also not been reviewed since April 2019. A member of staff said, "(Person) is on a pressure mattress so we don't need to reposition her." National Institute for Health and Care Excellence (NICE) guidance states that people cared for in bed, in addition to having pressure relieving mattresses, should be repositioned to help reduce the risk of developing pressure sores.

● People were at risk of not being supported in the event of an emergency such as a fire. We asked staff where information was held for people in the event of a fire. They told us they were not aware of where this information was held. The nominated individual told us there was no personal evacuation plans that the emergency services could access. The nominated individual told us these were kept on the computer and acknowledged that the staff or fire service would not be able to access this information easily in the event of an emergency. We also identified that 14 staff had not received fire safety training and 10 had not received

this for at least four years.
● At the previous inspection we identified there was no formal analysis of incidents to identify and learn from patterns and trends. This had still not been addressed at this inspection. We asked to see the records relating to accidents and incidents however to date these have not been provided. We spoke with registered manager after the inspection who told us, "We don't have a proforma to analyse accidents and incidents." This meant that the provider or registered manager could not demonstrate how they were assured that appropriate action was being taken to mitigate risks to people and to look for themes and trends.

As risks were not always being managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the nominated individual confirmed they had created a fire safety file in the event of an emergency and people had to be evacuated. They also told us they had since weighed people and assessed their nutritional and hydration risks.

Using medicines safely
● Medicines were not being managed in a safe way and there was a risk that people would have their medicine contaminated. There was a pill splitter in the medicine trolley that was used to cut tablets. There were traces of medicine still left on the instrument that has not been cleaned. Cleaning a pill splitter between uses is essential for good infection control practice as well as to prevent cross-contamination of medicines from one person to another.
● There were zeros placed on two of the Medicine Administration Charts (MARS) that according to the bottom of the chart meant, "Out of stock." On one MAR the person had not been given pain relief on eight occasions over a four-day period despite this being a prescribed pain relief that the person required each day. The same person did not receive their medicine for an iron deficiency on 25 occasions over 13 consecutive days. This again was recorded as being, "Out of stock." Although staff showed us the prescriptions had been requested prior to the stock running out there was no further evidence that this had been chased up before the medicine ran out.
● Where people required 'as and when' medicines there was not always guidance in place for staff on when this should be given to ensure this was done consistently and in line with prescribing instructions. This had been raised at the previous inspection and had not been addressed.
● Where hand written prescriptions had been entered on the MAR these had not been signed by a member of staff or counter signed. This was despite the service policy stating that hand written entries needed to be signed and, "The entry shall be witnessed by another person, who should also initial the entry."
● We asked staff if they had been competency assessed to administer medicine to people and they told us they had not. After the inspection we asked the registered manager if staff administering medicines had been competency assessed. They told us that no staff had been assessed for their competency to administer medicines safely. Therefore, the provider and registered manager could not be assured that staff administering medicines to people were suitably skilled to do so safely.

As people's medicines were not always being managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the nominated individual advised us that 'as and when' (PRN) medicines guidance was being placed into each MAR for people. We will check this at the next inspection. They also confirmed that the missing prescriptions had since been obtained.

Preventing and controlling infection

● At the previous inspection there were concerns with the cleanliness around the service and how staff were adhering to infection control practices. At this inspection we found the cleanliness had improved but there were some aspects to the infection control practices that required improvement.
● We were not assured that the provider was preventing visitors from catching and spreading infections. Although visitors were asked to wear gloves, masks and aprons and had their temperatures checked, we were not asked for information about our current health. This was despite the service policy on visitors including, "Screening questions that our staff will ask a visitor on arrival are: 1. Have you been feeling unwell recently? and 2. Have you had recent onset of a new continuous cough?"
● We were not assured that the provider was accessing testing for people using the service and staff. On the day of the inspection staff were due to be tested. However, arrangements had not been made by the registered manager to ensure that sufficient numbers of testing kits were available. That meant that staff were having to wait until these were ordered.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. One relative said, "I think it's homely and clean."
● 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.

At our last inspection of the service, we found the provider had not ensured there were sufficient staff deployed at the service to provide safe care to people and robust recruitment was not undertaken. We made a recommendation around this. Enough improvement had not been made at this inspection and the provider was now in breach of regulation 18.

Staffing and recruitment
● People we spoke with felt that at times there were not enough staff. One person said, "When you use the call bell, I sometimes have to wait quite a long time. I was left sitting on the toilet for quite some time the other day. I know they are busy though." Another person who was cared for in their room told us they didn't see staff much and that, "They don't care whether I'm dead or alive." A third said, "They could always use more (staff)." People also fed back that staff were, "Very hard working" and "Staff come as quickly as they can."
● At the previous inspection we made recommendations to the provider to introduce call bell audits to ensure care was being provided when people needed this. We also recommended the provider introduced a system to assess people's need to determine the number of staff needed on duty. At this inspection this had not changed and there was still no tool being used to determine minimum staffing levels on the basis of people's needs and dependency. The nominated individual told us they had not found an appropriate tool to use since our last inspection. One person told us, "I think there should be a formula to determine how many staff are needed."
● We spoke to the registered manager after the inspection who told us that call bells audits were not taking place. They said, "I know we used to have the facility to do it but not sure if we do anymore."
● We asked them how they determined staff levels and they said, "We just look at staff levels as we go along." They said they had looked online for a dependency tool and that, "Maybe we should start using one." They said they were not aware of any concerns with staff levels until the inspection.
● We found times during the inspection when people were not always supported by staff as they were too busy. Some people in their rooms were socially isolated as staff were not available to spend time with them.

● Staff told us there needed to be more staff on duty. They said there were four carers on duty each day including a senior carer however the senior was also required to administer medicines. Staff told us that people's needs were increasing and most people required two members of staff to support them with personal care. One member of staff said, "There should be someone to manage the rotas as the seniors have too much to do." To manage the workload, staff had a rota of when people had a bath or a shower which meant people did not always have the choice or flexibility in their bathing routines. One person said, "I have a bath once a week, but I can't recall which day I am on." A member of staff said, "We have a system of one person who has a bath every morning and four on the afternoon shift." They acknowledged this was in place due to staff workload.
● In addition to their essential care duties, care staff also had to allocate time to deliver activities and manage housekeeping tasks which added pressures on their time to support people. One member of staff said, "It's hard, we don't stop. On the later shift we have to do the cleaning and laundry. The call bells go on longer. We don't have time to sit and talk to people. I don't have time to read the care plans."
● Other comments from staff included, "People say they are bored. (Person in their room) hasn't got anyone to talk to", "We are feeling drained as there is not enough staff. We don't have time to talk to people. Call bells take longer to answer." They said there were times they turn the call bell off before the care was provided and reassured the person they would come back.
● There had been no staff recruited at the service since the last inspection, so we were not able to check on any changes in recruitment practices. We asked the nominated individual for four weeks of staff rotas prior to the date of the inspection. The nominated individual told us these records had been archived and they were unable to provide them. Therefore, we were unable to check that the minimum staff levels they had set each day were actually on duty.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the nominated individual advised us an additional member of staff had been rostered on each morning. We will check the effectiveness of this at the next inspection.

Systems and processes to safeguard people from the risk of abuse
● There was a mixed response from people about whether they felt safe at the service. One person said, "I feel safe in general." Another told us, "If you did start complaining about this and that, then you are very vulnerable." One relative told us, "I think she is very much well looked after." Another told us, "I have never had concerns about her safety."
● We found that people were not always protected from the risk of abuse. Staff we spoke with were not always familiar with what they needed to do if they suspected abuse. One told us, "If I suspected abuse, I don't know how I would react in that moment." They went on to say they would report it but were not clear on the process to follow. Another told us, "I have had no training. I would report it, but I have had no training. There's the odd case where staff might be a bit snappy." They did not recognise that staff being, 'snappy' with people could be potentially abusive behaviour.
● According to the training data 20 out of 49 staff had not receiving safeguarding training and the remainder of staff had not received training for over four years. Therefore, the provider and registered manager could not be assured that staff were adequately informed and knowledgeable about identifying and reporting safeguarding concerns.
● We identified instances where people had not had their prescribed medicine for a number of days. This had not been raised as a safeguarding with the local authority or investigated by staff at the service as potential neglect. The local authority also made us aware of three other allegations of abuse that had been made by external professionals against the service. These had not been investigated by the registered

manager in order to keep people safe from risk of abuse or ill treatment.

As people were not protected from the risk of abuse this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 the previous inspection we found that there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 17.

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

● At the previous inspection we identified that there was insufficient auditing and governance which meant that the quality and safety of care was not reviewed thoroughly or appropriately. At this inspection we found this had not improved. We continued to find shortfalls that had not been identified as the provider or registered manager were not undertaking audits of care delivery. For example, people had not been weighed since August and people's food and fluid records were not being analysed in order to assess their risk of malnutrition. There were no audits of care records or review of training that staff needed to complete. One person said about the service, "It has gone downhill."
● We were only provided with evidence of one audit and this was not used to ensure improvements took place. The nominated individual undertook a medicine audit in September 2020 and found concerns relating to the recording and administration of medicines. However, no action plan had been developed and the errors were still occurring on the MAR charts we reviewed for October 2020.
● Although we acknowledge that some internal décor may have been delayed due to the COVID pandemic; no steps had been taken by the registered manager or the provider to ensure that, at a minimum, people were not at risk of injury or infection from the use of broken equipment. After the inspection the registered manager told us, "Yes we should not have allowed that to happen."
● It is a requirement of the provider's registration that the most recent CQC rating is clearly displayed in the reception of the service and on the service website. However, on the day of the inspection the rating from a 2017 inspection was showing on both rather than the most recent rating published in January 2020. This was despite the nominated individual being reminded by us on in May 2020 to update their website with the correct rating. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● The registered manager continued to manage both Roseland and another location of a similar size operated by the same provider. At this inspection we continued to find that appropriate audits, training, supervision and review of records was not being completed consistently at this service. This was raised as a

concern at the previous inspection, yet steps had not been taken to address this. We asked the registered manager about this and they said, "Things have lapsed."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People told us they did not see the registered manager regularly and did not always have confidence that things would be addressed quickly. One person said, "I don't see management very often." Another told us, "The manager is not able to make decisions, so everything has to go through (the nominated individual)." A third said, "The management is poor." A relative told us, "The administration there is completely disorganised."
● There remained no formal system to gather people's views or to gain feedback. The last meeting for people took place in April 2019 and there had been no recent mechanisms used to obtain feedback from people or their relatives. Staff told us that there was a lack of communication with relatives. One told us, "There have been no newsletters recently to resident's families." They told us they thought it was important to keep families updated. Another relative said, "They could put more information on their website to update us."
● There was no formal management structure in place for staff when the registered manager was on leave. On the day of the inspection the registered manager was on leave for the week. Staff told us this was not communicated with them. One told us, "(Registered manager) is off for a week but we didn't know until today."
● Staff told us they did not feel supported or valued. Comments included, "We've had no thanks. On one shift three people died and we got no support", "We are not thanked or respected. When we ask for things, we know nothing will get done", "I don't feel supported. It's the residents and care staff that keep me here and "I don't feel supported or particularly valued. I feel they are often quick to criticise."
● There were no processes in place for staff to give feedback or raise concerns, such as through staff meetings or on-to-one supervision with the registered manager. Comments included, "I can't tell you the last time we had a staff meeting", "There are no staff meetings, we would all like that. We should have them" and "I feel valued by the residents but not by the management. You walk in with great ideas, but nothing changes." The registered manager told us after the inspection they did try and speak to staff but that "We haven't had a staff meeting properly for about nine months." They told us there was no specific reason for this.

The shortfalls in relation to the governance of the service were a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw from care notes that people had access to health care professionals. One fed back that to us that staff were, "Kind, caring and hard working." When people became unwell staff sought advice from appropriate health care professionals."

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. At the last inspection we identified that incidents were not being reported appropriately to the CQC. On the provider's action plan, they stated they had introduced electronic recording of incidents and this, "Should allow us to readily have the information to hand so that reports to CQC will be done in a timely manner from now on." However, we found this was not taking place and there was no electronic recording of incidents.
● Since the last inspection we have had to frequently remind the provider to send in notifications where

needed for instance in relation to deaths and for an extended period of absence of the registered manager.
● During the inspection we identified instances of safeguarding that should have been notified to the CQC, but no steps had been taken to do this by the registered manager. After the inspection the Local Authority made us aware of incidents of three safeguarding allegations that had not been notified to the CQC. These included allegations of neglect made by external health care professionals.

As notifiable incidents were not always been sent in to the CQC this is a continued breach of regulation 18 of the (Registration) Regulations 2009.