Mrs Elizabeth Owen

Onny Cottage Rest Home

Inspection report

Bromfield
Ludlow
Shropshire
SY8 2JU

Tel: 01584856500

Date of inspection visit:
08 December 2020

Date of publication:
07 April 2021

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
Onny Cottage is a care home providing support with personal care needs to a maximum of seven older people. Accommodation is provided in one adapted building. At the time of the inspection, four people were using the service.

People's experience of using this service and what we found
Risks to people's safety and well-being were not always considered and plans to mitigate risks were either not in place or had not been reviewed.

People were not protected by the provider's staff recruitment procedures. The provider failed to ensure staff received the required training and support to meet people's needs safely. People were not protected by the procedures for the safe storage, management and administration of medicines. The management of medicines were unsafe and did not ensure people received their medicines as prescribed.

Infection, prevention and control procedures did not protect people from the risk of infection or contracting avoidable infections.

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. The provider had failed to follow the principles of the Mental Capacity Act 2005 which meant people were not safeguarded from receiving care and treatment which was not lawful. Staff had not received up to date training about how to safeguard people from the risk of abuse.

The service was not effectively managed and there were no systems in place to monitor the quality and safety of the service provided. The provider had failed to act on the breaches of regulations identified at our last inspection. The provider did not always work effectively with other professionals to achieve good outcomes for people.

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. (Report published December 2019) and there were multiple breaches of regulations. 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 received concerns in relation to the lack of effective management and communication, infection, prevention and control procedures, staff recruitment and training and care planning. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 coronavirus and other infection outbreaks effectively.

Ratings from the previous comprehensive inspection for those key questions we did not look at 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Onny Cottage Rest 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 safe care and treatment and good governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 six 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? The service was not safe	**Inadequate**
Is the service well-led? The service was not well-led	**Inadequate**

Onny Cottage Rest 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
This inspection was carried out by one inspector.

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

Notice of inspection
The inspection was unannounced.

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, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with two people who used the service about their experience of the care provided. We spoke with two members of staff which included the provider and a senior carer.

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

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 our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. 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 protect people against the risks associated with equipment servicing, electrical safety, fire safety, gas safety, scalding and legionella. Environmental audits were not being carried out to ensure that risks to people were minimised.
- The provider was unable to produce evidence that the stair lift was safe to be used. They were unable to provide evidence of safety checks on fixed electrical wiring and portable appliances. The landlords gas safety certificate was out of date. This was seen and confirmed by the provider.
- Monthly checks on hot water outlets were not being carried out to ensure temperatures remained within safe limits. There were no records to confirm people were protected against the risks associated with legionella. Risk assessments had not been completed and routine testing certificates could not be provided. There were no records to demonstrate that regular flushing of taps and showers in unoccupied bedrooms were being carried out.
- Regular checks on the fire detection and alarm system were not being carried out. The provider was unable to locate the fire risk assessment.
- Risk assessments associated with people's health, well-being and personal care needs had not always been considered or regularly reviewed. This meant people could be at risk of receiving unsafe or inappropriate care.
- People were provided with call bell pendants which meant they could summon assistance when needed. However, risks had not been considered or plans put in place to mitigate risks for one person who was unable to use a call bell.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued 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 the provider had failed to follow safe procedures for the management and administration of people's medicines. 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

● People's prescribed medicines were recorded on their individual medication administration record (MAR). However, all entries had been handwritten and had not been signed by two competent staff to ensure the entries were accurate.
● The medicines trolley was stored at the top of steep steps leading down to the cellar with only a makeshift plank of wood, approximately four inches high preventing the trolley from falling. The trolley was not secured to the wall. The door to the cellar was locked however the key was kept on a hook outside of the door. This placed people entering this vicinity at potential risk of serious harm.
● People were placed at risk because staff had not received up to date training or assessments of their competency in the management and administration of medicines. This meant people could not be assured they would receive their medicines as directed by the prescriber.

Failure to follow the proper and safe management and storage of medicines placed people at potential risk of harm. We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. The is a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their medicines when they needed them. One person said, "I'm on lots of tablets and I always get them at the right time."

Preventing and controlling infection
● The provider failed to assess and manage risks associated with the control and spread of infection.
● Cleaning schedules were incomplete and had not been reviewed or updated since the corona virus pandemic. There was no regular wiping down of touch points to reduce the spread of infection.
● The infection prevention control policy (IPC) in place had not been reviewed or updated to reflect the COVID-19 pandemic. The policy was dated May 2008. This meant staff did not have access to up to date information about how to reduce the risk of infection. This placed both people who use the service and staff at risk of harm.
● Bins provided for the disposal of personal protective equipment (PPE) were not foot operated. This increased the risk of the spread of infection.
●The laundry was situated in a building attached to the back of the home. The walls and floor were not fitted with impermeable coverings which meant they could not be easily cleaned. There were cobwebs on the stone walls and there were no designated areas for dirty and clean laundry. This meant there was an increased risk of the spread of infection.
● At the time of the inspection the provider was not wearing a face mask which met with government guidelines.
● Staff had not received any IPC updated training since the pandemic.

The provider had failed to assess and manage risks associated with the control and spread of infection which could place people at risk. We found systems were either not in place or robust enough to

demonstrate infection control was effectively managed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had failed to ensure the lawful care and treatment for people who lacked capacity.
● The provider told us they had not made an application for a Deprivation of Liberty Safeguards (DoLS) for one person who lacked the capacity to consent to their care and treatment. There were no mental capacity assessments or best interest decisions in the person's care plan. This placed the person at risk of receiving inappropriate care and support.
● The provider had failed to ensure that all staff had received training about how to safeguard adults from abuse. This meant not all staff would know how to recognise or report any concerns which could place people at risk of harm.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were safeguarded from the risk of abuse. This is 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.

● People told us they felt safe living at the home and with the staff who cared for them. One person said, "I am very happy with everything. No complaints at all. I would speak up if I wasn't happy. I feel safe and comfortable. All the staff are very nice, and they are kind to me."

Staffing and recruitment
● The provider failed to ensure people were protected by their procedures for staff recruitment.
● All of the staff files we looked at were missing essential information to confirm that staff were safe to work with the people who lived at the home. This included references, health declarations and checks with the Disclosure and Barring Service (DBS).

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were protected by the provider's recruitment procedures. This is a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to ensure staff had the required skills, training, and support to meet the needs of people using the service. This meant people could not be assured they would receive a safe and effective service.
● We found staff training was either out of date or had not taken place in all of the staff files we looked at and assessments of their competency and understanding had not been carried out. Therefore, the provider was unable to assure us staff had the skills and competence to deliver a good and safe service.
● Staff had not received regular supervisions or appraisals which meant they were not provided with opportunities to discuss their role or to receive feedback on their performance.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff had the skills required to meet people's needs. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Records of any accidents or incidents were maintained however, no action had been taken to reduce the

risk of the accident happening again.

● The provider had failed to take appropriate action to address the breaches identified at the last inspection which demonstrated they did not learn lessons when things went wrong.

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 our last inspection the provider was unable to demonstrate safety, or the quality of the service provided was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements have not been made and the provider is still in breach of regulation 17.

- The provider had failed to implement effective systems to monitor the safety and quality of the service provided.
- Audits and checks had not taken place which meant that risks associated with the environment, fire safety, gas and electrical safety, equipment, hot water, legionella and infection prevention and control of the spread of infection had not been considered and there were no plans in place to mitigate risks to people. Servicing records were either out of date or had not taken place.
- The provider had failed to ensure staff were recruited safely and had failed to ensure they were provided with the necessary training and support to carry out their role safely.
- Policies and procedures in place had not always been updated to reflect changes in legislation. For example, the Infection Prevention Control policy (IPC) had not been updated to reflect the COVID-19 Government guidelines.
- Regular reviews of people's care plans had not taken place which meant that they were not always reflective of current risks or needs. This meant people could not be assured they would receive adequate care and support.
- The lack of audits and checks meant that the shortfalls and risks we found associated with the management, storage and administration of people's medicines had not been identified or rectified.

Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- There was no learning from accidents or incidents. Accidents and incidents were not reviewed which meant measures to reduce the risk of reoccurrence were not considered or implemented.
- The provider had not always worked effectively with other professionals. For example, the provider failed

to liaise with professionals when they were unable to meet a person's needs.
● We received concerns from the local authority about the provider's lack of action to support a person whose mental health deteriorated. The provider also failed to follow the principles of the Mental Capacity Act 2005 (MCA) for a person who lacked the capacity to consent to their care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● There were no systems in place to monitor the day to day culture in the home. There were no formal systems in place to seek feedback from the people who used the service or staff.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety or the quality of the service provided was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment failed to protect people against the risks associated with equipment servicing, electrical safety, fire safety, gas safety, scalding and legionella. failed to ensure that medicines were managed and administered safely by staff who were trained and competent to carry out the task. We found that you had failed to assess and manage risks associated with the control and spread of infection. We found that you had failed to assess the risks to the health and safety of service users receiving care and treatment and doing all that is reasonably practicable to mitigate such risks.

The enforcement action we took:

NOP was issued to cancel the provider's registration

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 failing to protect service users from abuse and improper treatment as you had failed to take appropriate action to ensure that a service user received care and treatment which was lawful.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance we found that you were not operating effective systems or processes to ensure compliance with the requirements of the regulations as you had failed to assess and monitor the quality and safety

of the service provided.

The enforcement action we took:

NOP to cancel providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed failing to operate effective recruitment procedures to ensure persons employed are of good character and have the qualifications, competence, skills and experience to perform the work for which they are employed as you were failing to carry out appropriate pre employment checks to demonstrate people were appropriate to work with vulnerable people.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing failing to ensure that staff had the appropriate training, and support to meet the needs of people using the service.

The enforcement action we took:

NOP to cancel registration