Hamberley Care 1 Limited

Rosewood House

Inspection report

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28 April 2022

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rosewood House is a residential care home providing nursing and personal care for up to 90 people aged 65 and over, including people living with dementia. They also had a unit dedicated to providing neurological care. There were 55 people living in the home at the time of the inspection.

Rosewood House has three separate floors that each consist of two units, able to support 15 people within each unit. The units have separate adapted facilities. At the time of our inspection, one unit on the first floor was not open as it had just completed renovation works.

The home changed its name from Hawthorn Green Residential and Nursing Home to Rosewood House in September 2021.

People's experience of using this service and what we found
People and their relatives were positive about the kind and caring attitude of the staff team. One person said, "I have built up a good rapport with the staff and feel they give me good care." All the relatives we spoke with felt the home had a welcoming environment.

People's medicines were not always managed safely. Issues we identified at the last inspection had not been fully addressed.

Infection prevention and control practices did not always ensure people were fully protected from COVID-19. Although the home was clean and hygienic and staff were reminded about safe practices, we observed regular poor compliance of staff wearing masks properly throughout the inspection.

Staffing levels were not always consistent across the units to be able to meet people's needs. People told us this impacted the care they received. Staff told us they regularly raised their concerns about how staffing levels increased the risk to people's care or being able to support people in a timely way.

Risks to people's safety and guidance for staff to follow to manage these risks were not always recorded or in place for staff to understand how to support people safely.

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

People and their relatives felt they had been well supported during the COVID-19 pandemic and had been kept updated when needed. One relative said, "The manager is brilliant, they will always try and sort out any problems."

Monitoring and auditing systems did not always identify and remedy any issues with the quality of the

service. Feedback from staff was mixed about the working environment and the support they received. Some staff told us they did not feel their issues were listened to.

The provider had failed to notify us about all the incidents that had occurred across 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 inspected but not rated (published 30 March 2021), which meant the rating at the time of the inspection did not change from requires improvement.

This is because we carried out a targeted inspection. We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received anonymous concerns in relation to staffing levels, the safety of people's care and support and general concerns about the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has remained as requires improvement based on the findings of this inspection.

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

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.

Enforcement
We have identified a continued breach in relation to the management of medicines. We have identified breaches in relation to staffing, good governance and failure to notify the CQC about incidents in the home.

We have sent a Regulation 17(3) Letter to the provider in relation to their failure to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activities. A Regulation 17(3) Letter stipulates the improvements needed to meet breaches of regulation, seeks an action plan and requires a provider to regularly report to CQC on their progress with meeting their action plan.

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rosewood House

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 Health and Social Care Act 2008.

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 consisted of one inspector, a pharmacy inspector, a nurse specialist professional advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Rosewood House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rosewood House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. The current manager had been in post since November 2021 and had submitted their registered manager application on 22 March 2022, which was still being processed.

Notice of inspection

This inspection was unannounced. The provider knew we would be returning on the second and third day of the inspection.

We visited the home on 20, 21 and 28 April 2022. An Expert by Experience made calls to people's relatives between 27 and 28 April 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any significant incidents that occurred at the service. 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.

We reviewed the previous inspection report and actions plans submitted after the last inspection. We contacted the local authority commissioning team and reviewed their recent safeguarding report and monitoring visit report from October and November 2021. We used all of this information to plan our inspection.

During the inspection
We met and had introductions with people who used the service and spoke with seven of them in more detail. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the care and support provided to people in the communal areas across different parts of the day, including mealtimes. We also spoke with one relative who was visiting during the inspection.

We spoke with 22 staff members. This included the manager, an operations manager, the head of quality, the operations director, the hotel services manager, six nurses and 11 care workers, known as 'homemakers'. We also spoke with a health and social care professional who was visiting during the inspection.

We asked the manager to share a questionnaire with the staff team to give them an opportunity to give us feedback about their experience of working in the home and heard back from a further eight staff members.

We reviewed a range of records, both on and off site. This included 23 people's care and medicines records and seven staff files in relation to recruitment. We also reviewed records related to the management of the service, which included incident reports, training records, handover records, quality assurance checks and minutes of staff and management meetings.

We carried out observations throughout the day in relation to infection prevention and control procedures and staff awareness of best practice.

We contacted 10 relatives over the phone between 27 and 28 April 2022 and spoke with nine of them. We also spoke with a further four health and social care professionals.

We provided formal feedback to the nominated individual and the management team via email on 6 May 2022. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

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 inspected but not rated, which meant it kept the rating of requires improvement that was awarded at the previous inspection. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection although we found no evidence that people had been harmed, the provider had failed to ensure the safe management of people's medicines and best practice was not always followed. 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.

- We saw people's medicines continued to not always be managed safely and in line with best practice. Issues that we highlighted at the last inspection had still not been fully addressed.
- Time sensitive medicines were not always given within a reasonable time frame. This meant that there was a risk that symptoms were not being managed effectively.
- Staff had not calibrated the blood glucose meter, which needs to be done when checking people's blood sugar levels to ensure the results are accurate. This meant that results obtained could not be relied upon as accurate.
- Staff did not always record if transdermal patches were still in place. A transdermal patch is a medicated adhesive patch placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. This meant that when a patch fell off, staff were not aware, and people's treatment may not have been effective.
- We found some staff were not always trained or had not been assessed as competent before they could administer people's medicines. This included staff giving injections to one person. This meant that there was a risk that people were receiving medicines in a way that was not safe or effective. We discussed this with the manager who suspended the staff involved from supporting people with their medicines and started an investigation.
- Staff did not always record the temperatures of medicines storage areas. In addition, when temperatures were outside the required range, action was not always taken to safeguard medicines supplies. This meant that some medicines may not have been as effective.

The provider failed to ensure the safe management of people's medicines and best practice was not always followed. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to people were not always properly assessed and staff did not have important information available to help them understand how they could support people safely. Although we saw examples of detailed information within people's risk assessments, it was not consistent across all of the records we reviewed.

● Records for two people showed they could display behaviour that challenged the service. There was no information or guidance about how to manage these behaviours, any triggers or how to deescalate any situations that might arise.

● Staff told us they did not always feel confident or equipped to be able to support them safely. One staff member added, "Although [person] can be calm, they also lash out and can be very aggressive."

● For one of these people, it stated in their records they were also at risk of leaving the home and injuring others, but there was no information or guidance about this or what staff needed to do if they did leave the home. This person left the home on two occasions and staff told us they did not know what to do in this situation. We discussed these issues with the manager who acknowledged more information was needed and would provide further information to staff on the relevant units.

● We also followed up issues raised with us regarding risks related to people's bedrails. Staff told us concerns had been raised with the provider in November 2021, which had been addressed. The management team were also informed at the end of February 2022 by the occupational therapy team that bedrail risk assessments were not in line with safety requirements. This was still in the process of being followed up at the time of the inspection.

● We observed issues with the call bell system, which had been malfunctioning for over two weeks. Although requests were made to repair the fault, there was no formal risk management plan in place at the time to ensure people's safety was monitored. Staff told us they had just been told to make sure they checked on people.

Although we found no evidence that people had been harmed, the inconsistencies within risk assessments created a risk to people's health and safety. The provider was not doing all that is reasonably practicable to mitigate risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. The nursing staff responsible for this had a good understanding of their responsibilities in making the relevant authorisations.

● We saw one condition related to a DoLS authorisation for one person was not always being met as records were not always kept. We discussed this with the manager during the inspection who said they would look into this.

Staffing and recruitment

● The provider did not always have sufficient numbers of suitably qualified, competent, skilled and

experienced staff deployed to support people's needs. From observations and feedback from staff, assessed levels of staffing impacted the care people received. Staff told us throughout the inspection their concerns around staffing in some of the units, which resulted in people being left in bed or receiving care later in the day.

● Samples of investigations and complaints reviewed during the inspection highlighted consistent themes around staffing issues that were raised and were acknowledged in the outcomes. For example, recent concerns raised by one relative in March 2022 about their family member not having their one to one staff member with them and left alone as the staff member had been asked to help out elsewhere had been confirmed.

● The majority of staff told us how staffing levels were insufficient and how it not only impacted people's care, but also their own health and wellbeing. Staff added they had raised these issues with management for a significant period of time and did not feel the issue was being addressed.

● Comments included, "The residents are left far too long in their own urine and faeces because there is never enough staff to give the residents the dignity and quality of life which every human being should have and that in turn makes me as a homemaker feel very upset and makes me feel I have failed at my job which in turn makes me very uneasy and mentally sad" and "There are many days where we had minimal staffing on our unit. Because of this there were days where we were unable to get all residents out of their rooms or their beds, we were unable to reposition residents who needed two hourly repositioning and residents had to wait to be fed or changed due to a lack of available staff to manage this."

● We also received mixed views from people and their relatives. One person told us how the delay in receiving their care in the morning impacted their day. A relative told us staff were moved around the units to cover shortfalls, which impacted the continuity of care.

● However, people and their relatives were positive about the attitude of the staff, and some relatives did not raise any major concerns. One relative said, "We understand they can be busy but they do come and do checks and I feel they are safe here."

The provider did not always ensure sufficient numbers of staff were deployed to make sure they could meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the concerns with the manager who highlighted staffing has been an issue since they started in November 2021 and highlighted issues with recruitment, including the challenges due to the pandemic. There was also a high rate of staff not turning up or calling in sick with limited notice, which proved challenging to find cover at short notice.

● Although dependency assessments were in place, after raising our concerns, the management team said they would start to reassess people's needs who appeared to be scoring lower than anticipated. The manager updated us on 4 May 2022 and confirmed some people's needs had been assessed as having a higher dependency than before.

● Concerns around staffing levels continued to be raised with us after the inspection, which we shared with the manager.

Preventing and controlling infection

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

● 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 promoting safety through the layout and hygiene practices of the premises.

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

● We saw the provider was facilitating visitors into the home. However, there was conflicting information that had been shared with relatives around COVID-19 testing requirements and what we had been told, as it was not in line with government guidance. The provider told us after the inspection they had decided to issue guidance that had stricter requirements than government guidance. This was because the home was located in an area that had very high case levels of COVID-19 and had been subject to closures on many occasions.
● We were not fully assured the provider was using PPE effectively and safely and making sure infection outbreaks can be effectively prevented or managed. We observed many examples of poor compliance of staff wearing masks properly throughout the inspection, despite regular reminders and posters displayed around the home. On one day of the inspection we had to ask staff members to put a mask on.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. Staff told us conflicting information about the frequency of testing within the home. We discussed this with the manager who acknowledged the advice from the local authority given on the morning of 20 April had not been shared with the staff team until we brought this to their attention on the evening of the 21 April, which was then sent out.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● There were safeguarding procedures in place and staff we spoke with had a good understanding of their responsibilities to make sure people were safe from harm and potential abuse.
● Although staff told us they had completed safeguarding training, training records across the home showed a number of staff were due refresher training. We discussed this with the manager who acknowledged this and were following up with staff to ensure training was updated.
● Whilst some of the staff we spoke with were confident any concerns they raised would be followed up appropriately, this was not consistent across all the feedback we received. Some staff felt where they had highlighted concerns around staff competencies and areas of poor practice, this had not been addressed.
● Although a safeguarding log was in place, it did not always contain the documents related to the investigation or have a record the outcome. There were also two safeguarding investigations that were not included and these needed to be requested. The manager acknowledged the log needed to be updated.
● The provider had an internal system with procedures in place for the reporting of any incidents and accidents across the home. We saw examples of best practice where learning from incidents had been discussed and shared with staff during meetings.
● However, there were a number of incidents that had been recorded that were overdue and actions had not been completed, some of which pre-dated the current manager. The provider acknowledged having the time to action these had been an issue and was working through them.

Requires Improvement

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 inspected but not rated, which meant it kept the rating of requires improvement that was awarded at the previous inspection. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider had failed to notify CQC of all safeguarding incidents and other notifiable incidents since the last inspection, of which they were required by law to inform CQC.
- We saw two safeguarding investigations that happened between December 2021 and January 2022 had not been notified. The provider had also failed to notify us when they had an event that stopped the service running safely, which was in relation to the faulty call bell system. The manager acknowledged this and said this had been an oversight on their behalf. The incident related to the call bell system was notified to us during the inspection.
- During the inspection, we were made aware of two incidents that involved the police, in relation to a person who left the home. We discussed this with the manager on 28 April 2022. The incidents had not been notified to us at the time of writing the report.

Failure to notify us was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. CQC is considering what further action they need to take against the provider for this failure to notify.

- Staff told us they had daily huddle meetings and spoke positively about the support they received from the nursing team to remind them about their key roles and responsibilities. However, we also received feedback from staff about the lack of support and presence of management at weekends, including the on call service is not always answered. Staff told us this left them feeling unsupported and isolated.

Continuous learning and improving care

- Although there were systems in place to monitor the service, the provider failed to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. This meant people using the service did not always receive a standard of care and support that was safe and appropriate to their needs.
- These processes had not identified issues that may have impacted on people's safety. We saw there were gaps in people's care records around repositioning, oral care and fluid levels that had not been addressed. This also included issues we found with the management of people's medicines. We could not be assured the provider was taking action in a consistent way to identify learning from incidents or ensure the appropriate action had been taken.
- Some of the staff we spoke with told us they had not received any fire safety training and could not explain

what they would do in an emergency. We discussed this with the hotel services manager, who confirmed 56 staff members had not completed this training.
● We followed up some concerns that had been raised with us related to staff competencies for moving and handling. Training records were not available for some of the staff members we had requested.
● We observed the lack of handheld electronic devices on one unit during the inspection which impacted the ability of staff to record their care interactions with people. Staff told us this issue had been raised previously but no action had been taken. We observed one staff member had to record notes on their arm. One staff member said, "This makes us look bad as we can't do the notes. We keep raising this but have not had a response."

The provider did not effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed these issues with the management team during the inspection. The provider requested an audit to be carried out to determine the number of electronic devices required. They also told us after the inspection where this issue had been raised previously in October 2021 and March 2022 on both occasions additional handsets had been ordered. The provider also sent out a memo to all staff to ask them to complete the provider's online mandatory fire safety module.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The majority of feedback from people and their relatives was positive about the home environment and their relationship with the management team. Comments included, "I'm very happy with Rosewood House. [Family member] loves it here and I have no concerns", "There are good vibes in the home, it is welcoming and homely. I'm over the moon they are here" and "I have really settled in well. I like it here and don't want to leave."
● We did receive some positive comments from staff about the manager and despite some of the issues, he worked hard to support them. One staff member said, "There have been changes in management and clinical leads, so it hasn't been stable. However, he is doing all he can."
● However, despite some of the positive comments, a lot of staff feedback raised issues around the support they received which resulted in a stressful work environment where they did not always feel listened to.
● One staff member said, "There is a lack of support from the management team. No feedback to emails and no action taken." Another staff member told us the working environment could have an impact on people. They added, "It can really depend on the team we work with. We can have good shifts, but also bad shifts. They can be awful at times."
● We discussed the morale of the staff with the manager during the inspection. They said, "I do feel it is improving. We have had some staffing issues and changes in the home. We do need to get better at feeding back about the actions we have taken."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider was working on improving opportunities for people and their relatives to provide feedback on their experiences of their care. Relatives told us they had been updated via email or over the phone, whilst some said they had been able to complete a satisfaction survey.
● The manager told us questionnaires for people were going to be implemented going forward. The manager also told us they had scheduled a relatives' meeting for the end of April to help provide further updates about the service, where relatives could visit in person at the home or join online.

● Positive feedback included, "Staff have been very good throughout the pandemic, with good communication with me via email and phone" and "I know the manager, they are easy to access and are approachable."
● Staff had access to a confidential employee assistance programme that was displayed throughout the home. Feedback from staff was mixed as not all staff felt valued and told us this impacted their own wellbeing.

Working in partnership with others
● The provider worked with a range of health and social care professionals, with the home also involved in regular multidisciplinary meetings to discuss any changes in people's health and wellbeing.
● For example, where one person had swallowing difficulties, staff arranged a GP to visit and there was further input from a physio and the speech and language therapy team.

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 told us they were aware of their responsibilities to inform people's relatives and make them aware if their family member had an accident or had been involved in an incident. One relative said, "I think they are very honest and have an open culture, I never felt they were hiding anything from me."
● However, one relative told us where they had been unhappy with a response to a complaint, they requested further information about their family member's care records on 14 February, 18 March and 6 April 2022 but had no response. We discussed this with the manager on 18 May to get an update on this information we received. They told us they had sent a response on 17 May 2022 and apologised for the delay.

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 did not always assess the risks to the health and safety of service users receiving care and do all that is reasonably practicable to mitigate any such risks. The provider was not always managing people's medicines safely. Regulation 12 (1) (2) (a), (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure sufficient numbers of staff were deployed to make sure they could meet people's needs. Regulation 18 (1)