Rosclare Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 26 March 2018 and was unannounced.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Rosclare Residential Home 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.

Rosclare Residential Home accommodates up to 19 people in one adapted building, at the time of our inspection there were 16 people residing at the home.

Following the last comprehensive inspection on 17 January 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe and Well-Led to at least good. We conducted a focused inspection on 09 August 2017 to check on improvements that the provider had made and found that appropriate action had been taken to meet the requirements.

However, at this inspection we identified on-going concerns about risks posed to people by the premises. The provider had not taken action to address hot water temperatures exceeding permitted safe levels in some parts of the home. A substance hazardous to health was not safely stored. This meant people were not sufficiently protected from the risk of injury or harm that could arise from scalding or burning from hot water and drinking hazardous substances.

We found that food items were not always appropriately stored or in date meaning people were at risk of eating foods that were not fit for consumption.

Action was not always taken to mitigate risks to people where issues had been identified. People had risk assessments in place but these were not always promptly updated to reflect a change in people's needs and provide guidance for staff on how to support people.

We also found the provider's current arrangements for monitoring the quality and safety of the service were ineffective. The registered manager had not reviewed checks they and the deputy manager had undertaken to identify any issues or concerns that may have posed a risk to people's safety, health and wellbeing. Staff were not fully up to date with the provider's training requirements. We were also concerned current checks and audits did not review all aspects of the service to give the provider the assurance they needed that the service was operating safely.

We identified three breaches of regulations during the inspection. These were in regards to safe care and treatment, staffing and good governance. You can see the action we have told the provider to take with regard to these breaches at the back of the full version of this report.

We have also made recommendations. The first was in regards to the provider ensuring staff knowledge, skills and competencies to manage and administer medicines safely, was reviewed annually. The first was about the home's environment and design not being as dementia 'friendly' as it could be. Although we saw there were some signs displayed throughout the care home to help people identify toilets and bathrooms, most bedroom doors lacked any visual cues in order to make the room more recognisable to people. We have also made a recommendation in relation to the review of activities at the home to ensure these provided personalised stimulation for people.

People were not provided with a choice as to their meal preferences, however they were offered fluids and snacks. People were supported to access healthcare professionals, however this was not always done in a timely manner to meet the needs of people at the home.

Staff were aware of how to report any concerns relating to abuse and there were enough staff to meet the needs of people at the home. The home appeared clean and hygienic.

Consent was sought from people in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff were caring and treated people with compassion. People's privacy and dignity were respected and people were invited to express their views in relation to their care and treatment. Staff knew the people they cared for well and we observed that people were treated kindly and with compassion.

The provider had a complaints procedure in place and staff were clear on how to respond to any concerns raised. People's end of life preferences were recorded to enable staff to support people with their choices.

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.
Various issues were identified in relation to the safety of the home including unsafe hot water temperatures, step free access and out of date foods.
Medicines were not always managed safely.
Action was not always taken to mitigate risks to people
There were sufficient numbers of staff and they were aware of how to report any safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff were not fully up to date with the provider's training requirements.
People were not provided with meal preference choices.
People were supported to access healthcare professionals but this was not always in a timely manner.
Consent was sought from people prior to supporting them.

Is the service caring?

Good

The service was caring. Staff knew the people they cared for well and knew their likes and dislikes. People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. Activities on offer were not always personalised to meet people's individual needs. People's end of life preferences were clearly documented. The provider had an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not well led. The provider did not have sufficient quality monitoring systems in place to analyse and remedy issues as they arose. There was no clear vision to drive the service forward and make improvements.

Rosclare Residential Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 26 March 2018 and was unannounced.

The inspection was carried out by two inspectors 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 care service.

We also observed the way staff interacted with people living in the home and performed their duties. During lunch on the second day of the inspection 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 spoke with nine people at the home and one visiting relative. We spoke to four support workers, the cook, the deputy manager and the registered manager. We looked at four people's care plans, 15 staff files and a range of other documents that related to the overall management of the service.

Inadequate

Is the service safe?

Our findings

At our previous comprehensive inspection of this service in January 2017 we identified issues relating to people not being sufficiently protected from risks of injury or harm posed by the environment. This was because the measures that were in place to monitor hot water temperatures were ineffective. At the follow up focused inspection, which we carried out in August 2017, we found the provider had taken appropriate action to improve the way they managed hot water temperatures in the home.

However, at this inspection we found hot water temperatures again exceeded safe levels. The provider required staff to routinely check and record the temperatures of all hot water outlets in the premises to ensure these did not exceed the maximum temperature of 44 degrees Celsius as recommended by the Health and Safety Executive (HSE) in their guidance 'Health and safety in care homes'. During our inspection we tested the temperature of hot water outlets in a communal ground floor shower room and bathroom and found them to be unsafe as they both exceeded 50 degrees Celsius.This meant people were not sufficiently protected from the risk of scalding from hot water. We also tested the temperature of a first floor shower room and found it was an uncomfortably cold 28 degrees Celsius. The registered manager told us that people did not receive personal care unsupervised. Records of weekly temperature checks undertaken by the deputy manager covered a randomised sample of rooms each week. These checks did not indicate there were any issues with water temperatures in the service and therefore staff were not aware water temperatures in the home were exceeding permitted safe levels.

In addition, we found a substance hazardous to health had been left unattended in an unlocked cupboard in the ground floor laundry room, which remained open throughout our inspection. Following our inspection we were informed that the provider had commenced storage of hazardous materials in the cellar when they were not in use.This meant people living in the home were not sufficiently protected from the risk of drinking hazardous substances.

Step free access to the building was not suitable for people to negotiate independently. We saw an external ramp leading from the backdoor to the rear of the home had a large drop on one side. We discussed this health and safety issue with the registered manager who acknowledged the ramp did pose a potential risk of harm to people and agreed to fix a safety barrier to the exposed side of the ramp to prevent people falling off it. Following the inspection the provider told us that a risk assessment had been recommended in relation to the ramp in 2009 and that they had completed this; resulting in people being supervised whilst using the ramp. After inspection the provider told us that a custom made handrail had been ordered.

On the first day of inspection the door to the basement food storage area was kept unlocked, and staff told us that this was the case whilst day staff were on duty. However, one person's room was next to the basement door and there was a risk that people at the home could have fallen down this stairwell. We brought the issue to the attention of the registered manager who spoke with the relevant key-holders. We observed on the second day of inspection that the door was kept locked unless staff were directly accessing it.

We checked the storage of foods across the home and found that some items in cupboard storage were out of date. On checking food items in the freezer we also found that food items had been stored that were not suitable for freezing. We raised this issue with the registered manager and these foods were disposed of. Items that were stored in the refrigerator were not labelled with their date of opening and the use by date. Therefore, people were at risk of receiving foods that were not fit for consumption. On the second day of inspection the registered manager arranged for these food items to be labelled appropriately.

Managers assessed and reviewed risks to people due to their specific health care needs. For example, risk management plans were in place for staff to follow to reduce these identified risks, which included nutrition, falls and mobility and skin care. The provider did not have effective arrangements in place to properly assess and reduce identified risks to people's health, safety and welfare.

Risk assessments did not always include sufficiently detailed guidance about the action staff needed to take to mitigate identified risks. For example, it was clear from one person's care plan we looked at that this person's behaviour might challenge the service at times, but the risk management plan that was in place to help staff prevent or deescalate such an incident merely stated 'staff are aware of ways to calm the situation down'. This meant the provider had not done all that they should to manage risks to people and ensure they and staff were sufficiently protected from the risk of injury and harm.

The provider kept a record of accidents and incidents that had occurred at the home. These detailed any recommended actions, however action was not always taken promptly in order to remedy incidents that had occurred. Where one person had suffered frequent falls the provider had not arranged for suitable monitoring equipment to be put in place to support staff to mitigate falls risk; despite this action being highlighted on the incident form. Neither had the person's risk assessment been updated to reflect their pattern of falls or provide appropriate guidance to staff on how best to support the person.

The provider did not ensure medicines were always managed safely. The service handled controlled drugs prescribed to people living in the home, which we saw were safely stored in a controlled drugs cupboard. However, checks we carried out of stocks and balances of medicines stored in the home identified one dosage of a controlled drug could not be accounted for. Medicines records showed us the service no longer kept a controlled drugs register, which the registered manager and staff confirmed. Without the controlled drugs register staff were no longer counter signing or keep a running balance each time they administered a controlled drug. This failure to follow relevant national guidelines around the proper recording of controlled drugs meant people might be at risk of not receiving their controlled drugs as prescribed. In addition, the registered manager arranged for a controlled drugs book to be put in place following our first day of inspection.

In addition, medicines were not always safely stored. The registered manager and staff confirmed they did not have a dedicated fridge to store medicines that required refrigeration, but instead used the kitchen fridge which was full of food and could not be locked. Furthermore, daily records of the maximum and minimum temperatures of the fridge and all three rooms where medicines were stored were not being appropriately maintained by staff. With no dedicated medicines fridge and poor record keeping of fridge and room temperatures where medicines were stored the provider could not ensure medicines were always kept at the correct temperature. Following our inspection, the provider told us they had ordered a dedicated lockable fridge for medicines, as well as introducing regular temperature checks.

Staff received training in the safe management of medicines. The registered manager told us the competency of staff managing medicines safely was reassessed annually. Although we found competency assessments for most staff, four out of 12 staff files we looked at did not contain an up to date safe

management of medicine's competency assessment record. Following the inspection the provider told us competency assessments records had been found for two of the four remaining staff members.

These issues we described above represent breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The negative points made above notwithstanding, people's care plans contained detailed information regarding their medicines and how they needed and preferred these to be administered. We looked at medicines administration records (MARs), which were completed by staff each time medicines were given. There were no gaps or omissions, which indicated people received these medicines as prescribed.

Staff understood the different types of abuse that people were at risk of and knew the action they would take to report any identified concerns. One staff member said "We would need to alert safeguarding and they would investigate." Staff received training in safeguarding and were aware of the external organisations they could whistle-blow to if this was required.

There were enough staff to meet the needs of people at the home and records showed that rota's were planned to enable staff to cover their duties. One staff member said "There's enough of us to do all the jobs".

Appropriate recruitment checks took place prior to staff commencing employment. Records showed that staff had been subject to Disclosure and Barring Service (DBS) checks, which the provider had recently reviewed for all staff. A DBS is a criminal record check employers undertake to make safe recruitment decisions. Two references were kept on people's files along with proof of address and photographic identification.

The premises appeared clean and there was a deep clean of people's rooms every fortnight. The cleaner had an active presence across both days of our inspection, maintaining the communal areas. We observed that staff used appropriate personal protective equipment (PPE) when supporting people so as to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Training records were held electronically and on a paper sheet on the front of staff training files. The training matrix we looked at reflected that staff were trained in areas such as dementia awareness, continence and manual handling, safeguarding and the requirements of the Mental Capacity Act 2005, food hygiene and fire drills. However, both the electronic and paper records showed that not all staff were up to date with the provider's training requirements. One member of staff was not clear on what training they had received. Both the registered manager and staff told us that training topics were covered at team meetings and delivered in-house. Staff were not always supported with training and development at the start of their role and at appropriate intervals during the course of their employment.

The issue above is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported through bi-monthly one to one supervision and annual appraisal of their work. One staff member said of supervision, "I quite enjoy it and get to talk about everything. Generally the residents and if we've got any problems."

We saw signage used in the home to help people orientate and to identify important rooms or areas such as their bedroom, lounges and dining rooms and bathrooms and toilets, was variable. For example, although we saw some people's bedroom doors had photographs of the person who occupied it, many lacked any visual clues to help people identify their room. We recommended that the service seek relevant guidance and research on the design of the environment for people living with dementia.

During a tour of the premises we found the lock on a shower/toilet room door was damaged, which meant it could not be locked when this room was engaged. We discussed the maintenance issue with the registered manager who agreed to fix the damaged lock without delay.

Although people were supported to have enough to eat and drink, they were not offered sufficient choice of food at mealtimes. One person said "It's all right. I eat what I'm given" and another told us "I can ask if I don't like something but I don't like to". On the second day of our inspection we saw everyone who lived in the home was served lasagne for their lunchtime meal. The registered manager and staff confirmed people were not offered a choice of hot food they might like to eat at mealtimes, although they could opt to have sandwiches instead. A member of staff said, "I think people would love to have more choice about what they eat at mealtimes." We discussed this lack of choice with the registered manager who agreed to talk to the people living in the home and the cook about improving the range of hot meal options people could choose between at mealtimes. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

People were not always supported to access healthcare professionals in a timely manner. One person had suffered a recent choking incident and the provider had not arranged for input from the Speech and Language Therapist (SALT) to review the person or put in place detailed guidance for staff in managing the

person's swallowing needs. Care files that we looked at showed that people had access to regular optician, dental and GP visits. People's files also recorded details of any hospital appointments they had attended.

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that where necessary capacity assessments had been completed, and that where authorisations were required these had been submitted to the local authority. Where best interests decisions were needed, records showed that these meetings had been held with the relevant professionals and family members.

Good

Is the service caring?

Our findings

The service was caring and we observed affectionate and thoughtful interactions between staff and people throughout both days of our inspection. Staff focused on people and seemed to genuinely enjoy the company of the people living at Rosclare. People looked at ease in staff's presence. Staff responded positively to people's questions and requests for assistance. Staff also gave people their full attention during conversations and spoke to people in a kind and considerate way. For example, during lunch we saw staff often ask people if they were enjoying their meal or needed a drink.

Most of the staff working at the home had been there for a long time and they knew the needs of the people residing there well. Staff were able to talk to us about people's preferences and their presenting needs. People's records contained a list of their likes and dislikes and staff were clear on where they could access this information.

People were treated with dignity and respect. One staff member said of delivering personal care, "I make sure the door is closed, I don't expose them and cover them with a towel. I always knock before I go in". We observed that staff treated people with compassion and where one person became mildly distressed staff were able to tend to their needs in a calm and reassuring manner.

People's religious and cultural beliefs were met where possible. One staff member said "The priest comes here to talk to residents" and the management spoke with us about regular services that people attended at the local church. People's care plans reflected whether they had any cultural beliefs and whether they wished to practice their faith of choice.

The home held monthly residents meetings and these were well attended by people. These discussed activities that people had been involved in.

Requires Improvement

Is the service responsive?

Our findings

Staff were able to talk to us about the activities that were on offer for people, however people did not always feel that enough stimulation was available to them. One person said "I like drawing but I don't know where I would do it." We did not observe people undertaking meaningful activities across the days of our inspection aside from watching television or listening to music in the communal lounge. The activity board was one sheet on the wall and it did not clearly define to people the choices that were available to them across the week. People did not have access to one to one sensory activities of their choice.

Staff told us that a local school visited for tea parties, a local nursery would attend for sing a song and play piano with people. We were also informed that a hairdresser attended fortnightly and that there was a library book exchange. The deputy manager had been trained to administer basic foot care to people and told us that people partake in this regularly.

People and their relatives were involved in the planning of their care. One relative said "I'm always involved in what's going on and the staff get in touch if there are changes." Staff told us that visitors were permitted to the service at any time and we saw that the deputy manager sent a monthly newsletter to people and their relatives. These included photos of recent activities undertaken including sing a song and pamper sessions.

We recommend that the service review people's preferences in relation to activities, to ensure that a clear timetable is established to allow people to partake in activities that are personalised to their needs.

People's preferences in relation to their end of life care were recorded in their care plans. Where necessary we saw that people's family members had been involved and that people had recorded their personal choices for their funeral arrangements. People had detailed how they would like to be cared for at the end of their life.

The provider had a complaints procedure in place and staff were clear on how to escalate issues if they were raised by people or their relatives. We checked the provider's complaints records and saw that no formal complaints were recorded, but that three verbal complaints had been received. Records showed that the provider resolved the issues raised promptly.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not always operated consistently by the provider, which meant people were not protected from risks that can arise from ineffective audits of the service. Although the provider had some relatively new quality monitoring systems in place which ensured care plans, medicines management, infection control, maintenance of the building, fire safety and activities were routinely checked; we found these arrangements had failed to pick up a number of issues we identified during our two-day inspection. For example, these systems had failed to identify all the health and safety, maintenance and medicines storage and recording problems we found during our inspection. This was because the information gathered through the audits had not been properly reviewed and analysed by the managers. As a result the provider did not develop the appropriate plans and take the necessary action to ensure the wellbeing and safety of people living at the home.

In addition, the registered manager confirmed they did not have any systems in place to routinely monitor the training and support staff received. This meant it was difficult for the registered manager to monitor gaps in staffs knowledge, training and support and when it needed refreshing.

The registered manager told us that the deputy manager was responsible for the primary day to day running of the home, meaning the registered manager did not always have full oversight of issues as they arose. At the time of our inspection we were told that the deputy manager had resigned and we were concerned that this would leave a gap in the day to day management of the home. Following our inspection the registered manager told us that they would be overseeing the deputy manager's role with the support of senior carers until a replacement was recruited.

This represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff that we spoke with felt supported by the management team at the home and were able to raise issues of concern or suggest improvements.

The registered manager regularly attended managers and provider forums across the borough to keep up to date with recent developments; as well as being accepted onto a leadership and development programme being arranged by the Health Innovation Network.

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 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that person's employed received the training required to enable them to carry out their duties.

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 The provider did not always do all that was reasonable practicable to mitigate risk to people. The premises were not always used in a safe way. Medicines were not managed safely.

The enforcement action we took:

We have issued a warning notice to the provider requiring them to become compliant with the regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems in place were not effective in identifying, recording and analysing findings to make improvements to the service.

The enforcement action we took:

We have issued a warning notice to the provider requiring them to become compliant with the regulation