Rosevilla Residential Home Limited

Rosevilla Residential Home

Inspection report

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Cheshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rosevilla Residential Home provides accommodation and personal care to older people, including people living with dementia. At the time of our inspection, there were 40 people living in the home.

People's experience of using the service and what we found
Governance systems failed to identify issues and drive necessary improvements to the quality and safety of the service. Issues we identified during the inspection had occurred partly due to a lack of understanding around the requirement for some actions and records that needed to be implemented in order to keep people safe.

People's prescribed medicines were not always managed safely. Risks associated with fluid thickening powder had not been considered and acted upon to ensure people were kept safe. Records required to show where and how topical medications such as creams and pain patches should be applied were not in place to evidence staff were following prescriber guidance. Advice had not been sought from a pharmacist to ensure that covert medicines (hidden in food or drink) were being given in a safe way. Staff had failed to follow prescriber guidance when administering medicines required to be taken separately to other prescribed medicines.

Risks to people's health safety and wellbeing had not always been assessed or documented in people's care plans to help staff support people safely. Risks associated with taking blood thinner medication and falls had not been considered as part of the care planning process. Staff did not have access to guidance around how to identify and respond to people who may experience low or high blood glucose levels.

Accidents and incidents were not subject to review or analysis to help identify patterns and trends. This meant there were missed opportunities to implement necessary changes to help prevent incidents occurring in the future. There were not always enough staff deployed across the service to support people safely.

Safeguarding concerns were recorded and acted upon appropriately. However, we could not always be certain they were reported to relevant agencies, including CQC, in a timely manner. We have made a recommendation regarding this.

Assessments were completed to determine people's capacity to make specific decisions. However, there was no evidence to show that best interests processes were being followed in line with the principles of the MCA. We have made a recommendation regarding this.

Whilst people were supported to have maximum choice and control of their lives and supported by staff in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We have made a recommendation regarding capacity assessments and best

interests processes.

The layout of the building was suitable to meet the needs of people who needed mobility equipment. However, we identified some issues regarding the atmosphere and the impact this could have on people living with dementia and those with increased anxiety and distress. We have made a recommendation regarding this.

Whilst people's needs had been assessed, we could not be certain care was being delivered in line with best practice. This was due to a lack of detailed and person-centred information in people's care plans and some monitoring charts not providing evidence that people had received their meals in line with their assessed needs.

People and family members spoke positively about the care provided by staff and told us staff were kind and caring and knew people well. Observations completed during the inspection further evidenced this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 8 January 2022).

Why we inspected
We received concerns in relation to risk management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection activity, we identified further concerns relating to MCA. As a result we included the key question of effective.

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 changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and recommendations
We have identified breaches in relation to medicines management, risk management, staffing and governance at this inspection.

We have made recommendations in relation to safeguarding incidents, MCA and the environment.

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.

Special measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? This service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? This service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rosevilla Residential 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 Health and Social Care Act 2008.

Inspection team
This inspection was completed was completed by 2 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.

Service and service type
Rosevilla Residential Home 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. Rosevilla Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were 2 registered managers in post.

One of the registered managers was also the provider and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This 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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 4 family members to gather their feedback about the service provided. We spoke with 5 staff, the registered manager and nominated individual.

We looked at 11 people's care records and 6 people's records in relation to medicines. We looked at 4 staff files and a range of other records relating to the overall management of the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question as good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
- Medicines were not always managed safely.
- Staff were not always following prescriber guidelines when administering people's medicines. For example, 1 person was prescribed medication that was to be administered 30-60 minutes before any other medication. However, staff were not following this guidance. This meant the person was at risk of prescribed medicines not working effectively.
- Additional charts were not in place to show where or how topical medicines, such as creams and pain patches, should be applied. This meant we could not be certain these medicines were being applied correctly.
- Risks associated with prescribed fluid thickening powder were not always considered and acted upon. For example, 1 person's thickening powder was found not securely stored in their room and therefore accessible to other people. This meant there was risk of people accidentally swallowing thickening powder.
- We could not always be certain that medicines required to be given covertly (hidden in food or drink) were being administered in line pharmaceutical guidance. Where required, there were no instructions for staff to follow to ensure these medicines remained safe and effective when being taken.

The provider had failed to ensure that medicines were managed safely. This placed people at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff responsible for the administration of people's prescribed medicines had received relevant training and had their competency levels regularly assessed.
- Medicines were mostly stored securely, and checks were completed to ensure they were stored within a safe temperature range.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Risks to people's health, safety and wellbeing were not always assessed, documented or managed effectively to prevent harm from occurring.
- Where people had a diagnosis of diabetes, there was no information or guidance available for staff to help them identify and respond to episodes of high or low blood glucose levels.
- Risks associated with prescribed blood thinning medication and falls were not considered as part of 1 person's falls assessment and care plan. This meant we could not be certain this person would receive appropriate medical treatment in the event they had a fall.
- Care plans for people who had been assessed as requiring their food prepared in a 'soft and bite sized'

texture did not provide information as to why this was needed. This meant we could not determine whether it was due to a risk of choking or their preference.
● There were no systems in place to review and analyse accidents and incidents to look for patterns and trends. This meant there were missed opportunities to reduce incidents occurring in the future. This placed people at risk of avoidable harm.
● We identified a large number of accidents and incidents had occurred in the service throughout 2022 and 2023. Most of these incidents had occurred within a particular time of the day. This trend had not been identified by the registered managers, therefore necessary changes had not been implemented to help prevent further incidents occurring.

The provider had failed to ensure that risk to people's health, safety and wellbeing had been appropriately documented and managed effectively. This placed people at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We could not always be certain the numbers and deployment of staff was enough to support people safely and prevent incidents occurring.
● Staffing levels were based on people's dependency levels. However, the tool used to assess safe staffing levels did not take into account the layout of the home. This meant staff were not always able to monitor people in communal areas due to lack of visibility.
● The failure to identify trends in relation to when most incidents occurred within the home, meant that necessary staffing levels had not been implemented during those times to help prevent them occurring. This resulted in people suffering unwitnessed falls and an increased number of incidents of challenging behaviour.
● People told us they often waited a long time for staff to respond to requests for support. This placed them at risk of avoidable harm.

The provider had failed to ensure there were enough staff deployed to support people safely. This placed people at risk of avoidable harm. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were followed to ensure new applicants were suitable to work for the service. This included a range of pre-employment checks such as references and DBS checks.

Systems and processes to safeguard people from the risk of abuse
● Whilst systems were in place to safeguard people from abuse, we identified some improvements needed to ensure people received the right support.
● Safeguarding incidents were recorded. However, we could not always be certain that incidents were reported to relevant agencies, for example the local authority safeguarding teams and CQC within a timely manner.

We recommend the provider review their safeguarding processes to ensure they are reported appropriately at the time the incidents occur.

● Staff had received safeguarding training and demonstrated a knowledge and understanding of how to identify and respond to safeguarding concerns.
● People told us they felt safe living at Rosevilla and family members told us they felt their relatives were safe and well cared for. One person said, "Yes I feel safe. I feel like they [staff] know me quite well. I am happy

here."

Preventing and controlling infection
- The registered manager took steps to ensure they were preventing and controlling infection.
- Staff were deployed to complete regular cleaning tasks to ensure the home was clean and hygienic.
- Staff had access to PPE and were observed wearing appropriate PPE when required.
- Staff had received infection prevention and control training.

Visits in care home
- Visits to the home were permitted in line with current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
- The service was not always working within the principles of the MCA.
- Whilst assessments were completed to check people's capacity to make specific decisions, the outcome of the assessment was not included within the document used.
- Where people had been assessed as not having capacity to make specific decisions, there was no evidence of a best interests decision being completed.

We recommend the provider reviews their assessment and best interests processes to ensure they are working within the principles of the MCA.

- Authorisations to deprive people of their liberty had been completed appropriately.
- People were offered choice and control over how they spent their day. Staff were heard asking for people's consent before carrying out support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Whilst people's needs had been assessed, we could not always be certain that care was delivered in line with best practice.
- Two people had been assessed as requiring their food be prepared in a soft and bite sized texture. However, food charts failed to demonstrate their meals were provided in line with their assessed needs.
- Where people had been assessed as experiencing increased anxiety or distress, care plans lacked detailed

information or guidance to support them in a way they needed.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet. However, we identified issues with the times that certain meals were provided. One person told us, "I get my lunch at 1pm then I have tea about 4pm. Then we only get a small snack about 7pm. I get quite hungry later on."
● We discussed the times of the meals with the registered manager who advised they would review this to ensure people received their meals at adequate times.
● Where people needed support with their meals, staff were observed providing this.
● People and family members spoke positively about the food provided. Comments included; "The food is lovely. I can't complain and good portion sizes" and "Meals are excellent and he [relative] is eating far better than when he was at home."

Adapting service, design, decoration to meet people's needs
● The environment did not always support the needs of people living with dementia or those identified has experiencing increased anxiety and distress.
● Loud noises from various sources in the main communal lounge area created a chaotic atmosphere. We were concerned that this could contribute to people's increased anxieties and incidents of challenging behaviour

We recommend the provider seeks reputable guidance in relation to dementia friendly environments.

● Most people's rooms were decorated to their choice with items of memorabilia.
● The corridors and communal areas were spacious and enabled people who required equipment to support with mobility to move around without risk.

Staff support: induction, training, skills and experience
● Staff received training relevant to their role and people's needs. Newly recruited staff received an induction prior to supporting people.
● Family members told us they felt confident staff were skilled in their role. One family member said, "They [staff] are excellent. They definitely know what they are doing. [Relative] is looked after well."
● Staff received regular supervision to discuss learning objectives and any concerns they have.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records indicated that people were supported to access health care services and support.
● Family members told us staff contacted relevant health professionals when their relative became unwell. We saw evidence of referrals to relevant professionals being completed where necessary.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- Governance systems had failed to identify issues and drive necessary improvements to the service.
- We identified a number of shortfalls that the provider's audits and checks had not found. For example, medicines management, risk management, accidents/incidents and staffing levels.
- The leadership team demonstrated a lack of understanding around risks and regulatory requirements.
- The issues we identified had occurred due to a lack of understanding around the requirement for some actions and records to be implemented in order to keep people safe. These shortfalls placed people at risk of avoidable harm.

The provider had failed to ensure governance systems were effective at driving necessary improvements to the quality and safety of care people received. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered managers were responsive to the feedback we gave during the inspection and took action to address the concerns we identified.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Improvements were needed to ensure a positive, person-centred culture was promoted within the service.
- Records relating to people's care and support needs were not always person-centred and lacked detailed information about how people needed or wished to be supported.
- Whilst we observed mostly positive interactions between staff and people, we identified some incidents where people were not treated with compassion when feeling anxious or distressed.
- People and family members spoke positively about the staff and the overall interactions and care people received. Comments included; "They [staff] always make a fuss of [people] and hug them when appropriate. The staff who work here are doing so because they care, not just as a job" and "Staff have got to know my [relative] so well and they are very kind to him."

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 registered managers were aware of their duty to be open and honest and when things went wrong.

However, we identified some issues with time delays in reporting incidents to relevant agencies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Meetings were held with staff to provide them with updates about the service and give then n opportunity to share their views.
- Feedback was gathered from people through regular surveys.
- The service worked with external agencies to ensure people received the right support.

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 There were not always enough staff deployed to support people to remain safe.

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 Medicines were not always managed safely. Risks to people's health, safety and well-being had not always been assessed and/or recorded in people's care plans. Accidents and incidents had not been reviewed or analysed to look for patterns and trends and prevent them occurring in the future.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had failed to identify issues and drive necessary improvements to the safety and quality of care people received.

The enforcement action we took:

Warning Notice