Signature of Epsom (Operations) Limited

# Rosebery Manor

## Inspection report

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Website: www.signature-care-homes.co.uk

Date of inspection visit:
10 August 2017

Date of publication:
21 September 2017

## 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

The inspection took place on 10 August 2017 and was unannounced.

Rosebery Manor provides accommodation, care and support for up to 95 people who require support with personal or nursing care. The home is set over three floors. The second floor provides care and support to people who are living with dementia, this unit is called The Oaks. The other areas of the home provide care for people requiring 'assisted living'. Some people lead a mainly independent life and use the home's facilities to support their lifestyle. On the day of the inspection there were 89 people living at Rosebery Manor, 62 people required personal or nursing care.

There was no registered manager in post. 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 and associated Regulations about how the service is run. An interim manager had been employed at the service since April 2017 whilst recruitment took place. The interim manager supported us during our inspection.

We carried out an unannounced comprehensive inspection of this service on 3 November 2016. After that inspection we received concerns in relation to safeguarding concerns not being identified and appropriately recorded to the local authority and the Care Quality Commission (CQC). As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to safe and well led key areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosebery Manor on our website at www.cqc.org.uk"

Safeguarding concerns had not always been reported to the relevant local authority to ensure thorough investigations took place in order to keep people safe. Staff had not consistently recognised the signs of potential abuse which had therefore not been reported internally or to external authorities. There had been a number of incidents between people which had not been reported and action had not always been taken to protect those concerned.

Risks to people's safety and well-being had not always been comprehensively assessed and monitoring systems in place to manage risks were not always effective. Accidents and incidents were not recorded and addressed to minimise the risk of them happening again. People's medicines were not always managed safely and medicines errors were not always investigated.

There was a lack of management oversight in the service. The manager was unaware of a number of incidents which had taken place in the service over recent months. Quality assurance systems were not effective in ensuring concerns were identified and addressed in a timely manner. Records were not always completed accurately and were not always accessible by the manager of the service. The provider had failed to ensure that the CQC were notified of significant events in the service in line with their legal

responsibilities.

There were sufficient staff deployed to meet people's needs and people did not have to wait for care. However, people told us that the high use of agency staff was a concern to them. We have made a recommendation regarding this. This is because although enough staff were caring for people agency staff may not know everyone of their individual needs and preferences and this affects the care they receive. Robust recruitment practices were followed to ensure that staff employed were safe to work in the service.

People had the opportunity to contribute to the running of the service through forums, resident meetings and annual questionnaires. Where concerns or improvements had been suggested these had been implemented. Staff felt supported by the management of the service and felt their views were listened to.

During the inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

## 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 consistently safe.

Staff had not recognised and reported safeguarding concerns. Incidents between people were not being reported or dealt with effectively to protect them.

Risks to people's safety and well-being were not effectively monitored.

Accidents and incidents were not always reported and were not monitored to prevent reoccurrence.

People's medicines were not always administered safely.

There were sufficient staff deployed to meet people's needs although the high use of agency staff had an impact on people's care. We have made a recommendation regarding this.

Safe recruitment processes were in place.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

There was no registered manager in post.

Quality assurance systems were not effective in identifying concerns and ensuring continuous improvements.

Records were not always accurately maintained.

Notifications regarding significant events had not been forwarded to CQC in line with registration requirements.

People and their relatives were given the opportunity to give feedback on the service.

Staff told us they felt supported by the management of the service.

# Rosebery Manor

**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 checked 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.

We completed this focussed inspection following concerns received from the local authority safeguarding team that safeguarding concerns were not being shared with the relevant authorities to enable thorough investigations to be completed. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led?

This inspection took place on 10 August 2017 and was unannounced. The inspection was carried out by three 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.

Before the inspection, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also contacted the local authority quality assurance team.

As part of our inspection we spoke with twelve people who lived at the service and observed the care and support provided to them. We spoke with one relative, seven staff members, the manager and the group care quality manager.

We also reviewed a variety of documents which included the care records for eight people, medicines records and various other documentation relevant to the management of the home. These included employment records for six staff members, quality assurance reports, policies and procedures and accident and incident reports.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at Rosebery Manor. One person told us, "You'd have to be a worrier not to feel safe here." Another person told us, "I have never thought about my safety – that's how safe I feel here." A third person said, "It's safe enough that I don't even consider locking my door at night." One relative told us, "I consider that Mum is safe and very well cared for by well trained staff who understand her needs."

Despite these positive comments we found that risks to people's safety were not always addressed to ensure they received safe care.

Safeguarding concerns were not always acted upon and were not always reported to the local authority safeguarding team. Prior to the inspection we were informed by the local authority that the service had failed to notify them of a number of safeguarding incidents which had occurred over the past three months. We reviewed accident and incident records in addition to people's daily records to identify any instances of potential abuse which had occurred in the service. Records showed that on four occasions over the previous two months incidents had occurred where people had been physically aggressive towards others. On one occasion this had resulted in a person sustaining a small skin tear. None of these incidents had been reported to the local safeguarding authority in order for them to monitor and investigate the action taken. There was no evidence that people's care plans or risk assessments had been reviewed as a result of incidents occurring. No records were available to show that people's relatives or next of kin had been informed of these incidents. Following the inspection we informed the local authority safeguarding team of the concerns identified.

Incidents of verbal abuse and threatening behaviour were not always recorded. We spoke with three staff members who told us that instances of verbal abuse or threatening behaviour by people were not recorded as incidents. Daily records showed that two people living in one area of the home were regularly verbally challenging towards others. Staff told us they would reassure people when this happened. This meant that trends in incidents of this nature could not be analysed or investigated in order to implement measures to help reduce people's anxiety. In addition this meant that the impact on others could not be assessed to ensure people felt safe in their home.

Records showed that staff had received training in safeguarding people from abuse and staff were able to list the possible categories of potential abuse. However, the lack of recording and reporting demonstrated that staff had not always transferred their training and knowledge into practise. Staff told us that they would report any concerns to the shift leader, nurse or manager on duty who would report further if required. None of the staff we spoke to were able to tell us about the whistle-blowing procedure should they believe that action had not been taken by the service to address safeguarding concerns.

The failure to ensure systems and processes were in place to protect people from potential abuse and the lack of reporting to the local safeguarding authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were not always recorded, investigated or analysed to ensure that measures were put in place to prevent reoccurrence and keep people safe. One person records recorded, '(Name) was very agitated while trying to transfer her from chair to wheelchair accidently sustained her left skin tear.' This incident had not been reported on the accident and incident monitoring system. There was no detailed analysis regarding how the skin tear had occurred and the incident had not been investigated. The person's care plan and risk assessment had not been reviewed following the incident. There was evidence available that the person had received treatment from the nurse on duty who told us they were aware of the incident. We spoke to the manager about this who told us the incident had not been reported to them. Following the inspection the provider informed us that they were aware of shortfalls regarding incident reporting and recording and this had been identified as a training need.

The provider's policy gave clear guidance to staff regarding the reporting of accidents and incidents. However, this was not always followed by staff. One staff member told us they would only report incidents which involved falls, breaks or calls to emergency services. Another senior staff member said that the expectation was that staff would report to the senior on duty when an incident and accident has occurred. The senior staff member would make a decision as to whether it was recorded on the monitoring system or not. This meant that the staff member witnessing the incident may not be writing the incident form. We found there was a lack of detail contained within accident and incident reports and follow up actions were not always taken. We reviewed three people's records who had recently experienced falls. We found that care plans and risk assessments had not been updated to reflect this and no additional control measures had been implemented to mitigate risks.

The accident and incident records were stored electronically with a system in place to evaluate and recommend actions. All records were automatically sent to a senior manager to review. We found that reviews had not been completed and no actions had been recorded. The system did not allow for a systematic review to identify trends and minimise the risk of reoccurrence. We spoke to the manager about the number of incidents which still required review. They told us that they were aware that a number of reviews were outstanding due to a senior staff member not currently being at work. They added that they had alerted the provider of their concerns regarding the ability to analyse records to identify any developing trends. The manager was unaware of a number of incidents we asked them about.

Risks to people's safety and well-being were not always identified and addressed. We reviewed care records for three people who were assessed as being at high risk of malnutrition. One person's records stated that their food intake should be monitored and they should be weighed weekly. Records showed that the person had not been weighed between April and July 2017 when a 4 kg weight loss was noted. Food and fluid charts for the person were not completed comprehensively with gaps on a number of days. One person's records showed they had experienced an 8% weight loss between July and August and another person a 6% weight loss. Neither persons records contained evidence that they had been referred to their GP to ensure there were no underlying health conditions causing their weight loss. Another person was assessed as being at risk of dehydration and required their fluid intake to be monitored. Records showed that for the period of 1 July to 1 August 2017, they were having a daily average of 227ml. The manager told us they believed this was a recording issue rather than the person not being supported to have a safe quantity of fluids. However, this demonstrated that fluid levels were not routinely monitored to ensure risks to people's health were mitigated.

One person's care plan showed that they were living with diabetes and required their blood sugars to be monitored twice daily. Records showed that the person's blood sugar levels were only monitored once each day and showed a high and erratic pattern. The person's GP had reviewed them regularly and recorded that the person's blood sugar levels were erratic. There was no diabetes care plan in place for the person to

guide staff on safe blood sugar levels for the person, how to support them when making food choices or how to identify if the person required medical intervention. Food records showed that the person had a diet which was high in fat and sugar. There was no indication that specialist diabetic foods were provided to the person to support them with maintaining their health. We spoke to one staff member about our concerns. They told us, "Staff are aware that (name) needs to eat healthily and do try and encourage it but we can't force them."

People's medicines were not always managed safely. One person's daily records stated they had only taken two of their prescribed medicines and refused the rest. The remaining medicines had been left in a pot in the medicines cabinet within the person's room. The person's MAR chart did not indicate that any medicines had been administered that day. When we spoke with the staff member they told us that the person had only taken one tablet and they had recorded this incorrectly on the daily records. The person's MAR chart also showed a number of gaps in recording. One person required their pulse to be taken prior to taking of their medicines. A review of a three week period showed their pulse had not been taken on eight occasions. There was no guidance in the persons MAR charts to guide staff as to what the person's pulse rate should be or the action to take if this was not within safe limits.

Incident records viewed highlighted that eight medicines errors had been reported over a five week period. There had been no review completed of how the error occurred, what remedial action was taken to ensure the person was safe or what additional measures had been implemented to prevent reoccurrence. A review of a further seven MAR records showed gaps in recording which had not been reported or investigated. One incident record described that a tablet had been lost in a communal area of the home. The tablet concerned presented a significant risk if taken by someone for who it hadn't been prescribed. Records did not show that a concerted search had taken place to find the missing table. A record two weeks later highlighted that a tablet had been found in the communal lift. A note said that checks would be made to see if this was the missing tablet. These checks had not been made at the time of the inspection despite the tablet being found in June.

Protocols were not in place for all people who required PRN medicines (as and when required). Protocols were available for people living within assisted living but were not in place for people living in the Oaks. This meant that staff did not have guidance as to when and how PRN medicines should be administered or the frequency or timings of administration. Where people had not required or refused PRN this was not recorded on their MAR chart. These concerns had been identified on a number of audits completed since May 2017 but had not been addressed. A number of people required their medicines to be administered at specific times. Although the times these medicines were required were written on the shift plan and within daily notes, staff did not record what time the medicines were actually administered on MAR charts.

Following our inspection the provider submitted an action plan which detailed how they intended to address the concerns identified in relation to people receiving safe care.

The failure to ensure risks to people's safety were monitored, that accidents and incidents were reviewed and that people received their medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by sufficient staff to meet their needs safely. We observed that staff were attentive to people's needs and did not observe people needing to wait for care. The manager told us that a dependency tool was used to assess the staffing levels required to meet people's needs. Rotas showed that minimum staffing levels were routinely met. The service was using a high number of agency staff whilst actively recruiting for permanent staff members. The manager said that wherever possible the same agency

staff were used in order to provide consistency for people. People told us that although they were happy with the care provided, they would prefer to have a permanent staff team. One person told us, "There are lots of staff that we don't know. I prefer the familiar faces." Another person said, "The staff change a lot with so many agency, just as you get to know someone they're gone." The manager told us they had recently recruited three new staff members and were in the process of making offers to a number of others.

We recommend that the recruitment of permanent staff continues in order to ensure that people receive continuity of care.

Safe recruitment practices were in place to ensure only suitable staff were employed. This included obtaining references, a full employment history, evidence of identification and a right to work in the UK and a disclosure and barring check (DBS) for a criminal record. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with people who use this type of service.

Plans were in place to ensure that people would continue to receive the support they required in the event of an emergency. The provider had developed an emergency continuity plan which gave detailed instructions of the action staff should take in the event of an emergency including fire, flood, IT failure or damage to the building. Contact details were contained within the document and alternative accommodation was listed. This meant that people would continue to receive care in the event the building could not be used.

Requires Improvement

# Is the service well-led?

## Our findings

People we spoke to told us they were not aware of who the manager of the service was but felt that any concerns they had would be addressed by senior staff responsible for the area of the service where they lived. One person told us, "I'd tell someone on this floor if I had any problems. I've no idea who the Manager is." Another person said, "I think that our two main nurses are the managers for this part. I'd tell them if I had any concerns." A third person told us, "My daughter has a good relationship with the management." One relative told us, "One of us is here every day and I feel that we have a good relationship with all the team."

There was no registered manager in post. The previous registered manager had left the service in April 2017. Since this time an interim manager had been in post. There had also been a number of changes with key members of the senior management team. It was clear from discussions with the manager and senior staff that this had led to a lack of oversight within the service. The manager and provider had not been informed of a number of safeguarding concerns in the service and senior staff were not always aware of their individual responsibilities. Following the inspection the provider forwarded an action plan which detailed how communication systems would be addressed to ensure that the manager had a comprehensive overview of the service. The provider also informed us that they were in the process of recruiting a registered manager for the service.

Quality assurance systems were not effective in ensuring continuous improvements. The service conducted a number of audits to monitor the quality of the service provided. These included medicines management, infection control, pressure care and food, drink and dietary care. In addition, a quarterly provider audit was completed by a member of the quality assurance team. A review of medicines audits identified the service had reached a 93% compliance rate in May 2017. However, a pharmacy audit completed in April 2017 by an external pharmacy had identified thirteen actions which needed to be addressed immediately. These included the stock control and administration of PRN medicines, no PRN guidance in place, missing signatures in MAR charts and the unsafe storage of some medicines. A provider audit reported in June 2017 also identified concerns regarding medicines management and the robustness of the audits completed by staff. The concerns identified during our inspection evidenced that action had not been taken to ensure that these concerns were rectified and people were receiving their medicines safely. The audit relating to people's food, drink and dietary care largely focussed on people's dining experience rather than people's nutritional care needs. This meant that gaps in recording of people's nutritional monitoring and the failure to take action when weight loss was noted had not been identified. There were no audits available relating to the monitoring of accidents and incidents and this had not been referred to in the most recent provider audit.

We spoke to the manager about the audit process in place in the service. They told us they were unable to access a number of audits including care record reviews as these had been completed by another senior staff member who was not available. We asked how the results of audits were monitored to ensure that actions were addressed. The manager told us that this was discussed at a monthly audit meeting with the senior staff member responsible. They told us minutes of the meetings were not maintained so we were unable to check the effectiveness of this process or any corrective actions taken. The manager shared an

action plan which had been developed from the most recent provider audit. The timeframe for the completion of actions was the end of July. However, we found a number of actions had not been completed at the time of our inspection including actions relating to medicines, the updating of care records and the monitoring of accidents and incidents.

Records were not accurately maintained and handover information was not always read by staff. Prior to our inspection we were informed that during an investigation by the safeguarding team records relating to the person at the centre of the investigation had been deleted. The provider had taken immediate action to re-instate the records and investigate these concerns. As previously reported we identified a number of areas where accurate records had not been maintained including the administration medicines and accidents and incidents. Staff told us that handovers took place in the service on a daily basis. In addition staff were not able to access the electronic recording system when starting their shift until they acknowledged they had read the handover information. However, staff told us that there were some staff acknowledging the notes without reading them. One staff member told us, "Staff often sign but haven't read them which means communication can be poor. It can be frustrating."

The failure to effectively monitor the quality and safety of the service and to maintain complete and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events. As reported, we were informed of a number of safeguarding concerns by the local authority safeguarding team. The service had not contacted CQC at any stage of the safeguarding process to alert us to the on-going safeguarding investigation. In addition, we found a number of safeguarding concerns during the inspection which the provider had failed to notify us of to enable us to effectively monitor the service provided.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

People had the opportunity to contribute to the running of the service. An annual survey was sent to residents and family members to gain their views of the service provided. The response rate was positive and people expressed satisfaction in most areas. The results had been published in June 2017 and the manager told us they were in the process of compiling an action plan to address areas with a lower satisfaction rating. We observed that action had been taken immediately following the survey to address the maintenance of the garden which had been people's primary concern. The results of the survey had been discussed in the residents meeting and assurances given that concerns would be addressed. Regular forums were held in the service to discuss areas including food and activities. Minutes showed that these forums were well-attended and that suggestions made were acted upon.

Staff told us they felt supported by the management team. One staff member told us, "I like (manager), she is very approachable. She always comes back with feedback. (Unit manager) being here has had a positive impact. I think management listen, they tell me that I go above and beyond." Another staff member said, "I feel supported and I'm not scared to ask if I don't know anything." Regular staff meetings were held within the service, including heads of department, clinical meetings and general staff meetings. Minutes were maintained and showed staff were able to contribute to the running of the service. For example, in a recent staff meeting staff had requested a review of the rota system and had been asked to contribute to the process.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure that risks to people's safety were monitored, that accidents and incidents were reviewed and that people received their medicines safely |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure systems and processes were in place to protect people from potential abuse and had failed to report concerns to the local safeguarding authority. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to effectively monitor the quality and safety of the service and to maintain complete and contemporaneous records. |