Rockley Dene Care Home Ltd

Rockley Dene Nursing Home

Inspection report

Park Road
Worsbrough
Barnsley
South Yorkshire
S70 5AD

Tel: 01226207916

Date of inspection visit:
20 January 2022

Date of publication:
25 March 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Rockley Dene Nursing Home is a residential care home providing personal and nursing care for up to 34 people in one adapted building over two floors. Seventeen people were living at the home at the time of inspection.

People's experience of using this service and what we found
We found systems and processes used to ensure the service was running safely were not effective. We observed a lack of leadership, direction and oversight.

People's safety and welfare was compromised and there was a lack of understanding of the risks and issues and the impact on people using the service. Quality assurance systems were ineffective and unreliable in identifying shortfalls, and where improvement was needed.

We identified significant shortfalls with how the provider and management team were responding to the COVID-19 pandemic. People's health and safety was at risk due to shortcomings in infection prevention and control. The building was not hygienic. This put people at risk of infection.

Risks associated with people's behaviours were not managed safely. Risks had not always been assessed and there was a lack of guidance about how to manage some people's behaviours. Incidents and accidents were not effectively reviewed to ensure lessons were learnt to drive improvements.

Staff were not always deployed effectively to ensure people's needs were met and the staffing levels meant people did not always receive a dignified service. Systems in place to safeguard people from abuse were not effectively implemented. Following the inspection we shared our concerns with the local authority.

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 requires improvement (published 26 August 2021) and there was three breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The overall rating of the service has changed from requires improvement to inadequate based on the findings of this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about areas of concern such as infection control and staffing. A decision was made for us to inspect and examine those risks.

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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to fire safety, infection control, risk, environment, staffing, staff training, dignity and respect, personalisation, leadership, management and governance.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rockley Dene Nursing Home

Detailed findings

Background to this 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 included checking the provider was meeting COVID-19 vaccination requirements. 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
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not available on the day of the inspection.

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, including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with two deputy managers, an agency nurse, an agency care assistant, an admin worker, the maintenance worker and the laundry assistant.

We reviewed a range of records. This included three people's care records in full and six others in part as well as multiple medication records. We looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke and met with external stakeholders and other regulatory bodies.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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.

- Risks to people were not always assessed prior to them moving to the home. This meant staff were unable to follow guidance to help ensure people were consistently supported safely.
- Records relating to people's safety were not always up to date or accurate. For example, some people's mobility, dietary requirements and/or clinical information such as diabetes were not accurate or provide enough information. This meant staff were unable to follow guidance to help ensure people were consistently supported safely. For example, where people were at risk of choking or aspiration staff did not have the up to date information about people's dietary requirements. The staff were not aware of those people who required fortified diets or who had allergies.
- The provider failed to implement a comprehensive and accurate handover for all staff. This was of particular risk and concern because the home was regularly using agency staff.
- Fire safety records had not been maintained. We found six people living in the home did not have a personal emergency evacuation plan. This meant should evacuation be required; some people may not be accounted for or others needs may not be met for a safe evacuation.
- The physical environment posed risk to people's health and safety. Areas which may cause harm to people were not secured. For example, the laundry, a cupboard containing potentially hazardous cleaning materials and sluice rooms were unlocked. We found toiletries left in a bathroom. Not all radiators had protective coverings to protect people from the risk of burns. Older people's skin is more fragile and sensitive to heat.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we shared our findings with the local authority and asked the provider to tell us what they would immediately do to address the risks.

Staffing and recruitment

● The service was understaffed at the time of out inspection.

● We reviewed staff rotas and found on some days there were no nurses on the rota. This meant we could not be assured people had not been placed at risk of not having their nursing needs met.

● There was a significant use of agency staff and this was reflected in staff rotas. There was insufficient information to confirm the agency staff had the required skills and experience. This meant there was no assurance suitably trained and experienced people were supporting people.

● There were no kitchen staff on site at the service so care staff were preparing meals, drinks and snacks, laundry and answering calls. We observed people sat in the communal areas for long periods of time with no staff present. When staff did go into the communal areas it was to undertake support tasks. We observed people not recognising each other's personal space, which resulted in verbal altercations between some. There were no staff in the area to defuse or distract these engagements.

● Throughout the inspection, we heard the alarm sounding which summoned staff assistance. On one occasion, the alarm sounded for 18 minutes. People told us this happened every day. This showed some people's needs were not being met in a timely a manner. The long alarm calls were also disruptive to the people living in the home.

We found no evidence people had been harmed however, the providers did not deploy enough suitably qualified, competent and experienced staff. This placed people at risk of harm. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider told us they were actively trying to recruit staff. They also said a number of staff were absent due to testing positive for COVID-19.

● The deputy manager said they had given agency staff information about people; however, this was not before they supported people.

Preventing and controlling infection

● Multiple areas of the home were unclean and unhygienic. We found laundry bags and dirty laundry in the bathroom.

● Staff were not using Personal Protective Equipment (PPE) safely.

● People were not always provided with toilet rolls, hand soap or paper hand towels in communal toilets. We observed people using the toilets and not having access to hygiene equipment to maintain personal hygiene.

● The provider did not have an adequate system for adequately monitoring the take up and testing of staff. Following our inspection, the provider confirmed they had put a system in place to monitor staff testing. We will review the effectiveness of these measures at our next inspection.

● PPE was not being disposed of or stored safely. Poor systems for disposal of PPE and sanitary waste placed people, staff and visitors at risk of infection.

● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed. An agency staff member told us they had entered a person's room to support them with personal care. On leaving the room they learnt the person was unwell and required staff to wear specific personal protective equipment. They had not worn the required equipment as they were not aware of the person's needs. This placed people and others at risk of avoidable harm.

Visiting in care homes

The service was not always following government guidance in relation to visiting.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

This was a breach of regulation 12(1)(2)(h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as government guidance around managing the ongoing pandemic was not being followed.

Using medicines safely

- Medicines were not managed safely which placed people at risk of harm.
- One person's medicine was not accurately checked. They were not given their prescribed medication over a period of two weeks. This placed the person at risk of harm. There were no records of people's prescribed topical medicines being applied. This meant there was an increased risk of harm because people had not received their medicines as prescribed.
- One person was prescribed a pain relief patch. However, the transdermal patch chart had not been completed. This meant we could not see if the patch had been applied according to the prescriber's instructions. This left the person at continued risk of pain and discomfort.
- Protocols to guide staff were not in place where people were prescribed medicines to be given as when required. For example, some people were living with dementia and were not able to tell staff when they required medicines such as pain relief. Following our inspection, the manager has told us this information has now been put in place.
- Medicines were not always stored or recorded appropriately in line with best practice. The monitoring and ordering process for medicines was not robust. We saw people going without medicines due to stock levels not being checked and medicines being re-ordered in an appropriate time frame.

We found no evidence people had been harmed; however, people had been placed at the risk of harm from unsafe administration and management of medicines. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Systems to ensure people were protected from a risk of abuse were inconsistent and not operated effectively.
- We were not assured the provider and staff understood their individual and collective safeguarding responsibilities.

Learning lessons when things go wrong

- There were no clear processes in place to learn lessons and improve practice.
- There was no record of actions and lessons learned taken forward from recent accidents and incidents at the service.
- The deputy manager was unable to demonstrate how they identified any trends or themes in incidents across the service, and where improvements were needed in order to minimise risks of similar incidents.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; the provider and management caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy was not consistently upheld. People looked unkempt, their hair was not brushed, and/or were unshaven.
- The provider and management had not ensured toilet rolls, hand soap or hand towels in communal toilets were available to people. The impact on people's dignity and their ability to remain independent was not considered.
- We found people were not always supported by staff in accordance with their needs and the care provided was inconsistent. Some people had to wait a long time for their personal care needs to be met and their dignity upheld
- Staff did not have time to provide effective care in a compassionate and supportive way. Staff provided basic support and social interaction with people was reserved primarily for when staff were completing a task. This did very little to promote people's independence, choice and wellbeing.
- Staff were not present for extended lengths of time in the communal areas. So, people's distress or anxiety were not responded to promptly.
- Professionals we spoke with felt the service did not always accommodate people's needs. Comments included, "The home should be shut down" and" I wouldn't put my parent in here, it needs shutting down."

This is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

- People had little control over their lives because there was a lack of opportunity to make choices about how to spend their day. There were no activities for people to participate in and interactions between staff and people were mainly focused on completing tasks.
- Care was not person-centred, and people were not always cared for in a safe way.
- The provider had not ensured people had received care that supported them to maintain their health and well-being.
- People were sat in the communal areas for long periods of time with no staff present. This showed people were at risk of social isolation. We found the registered provider had not ensured people living with dementia did not become disengaged with their surroundings.

Supporting people to express their views and be involved in making decisions about their care

● There was limited evidence people were supported to express their views and were involved in decisions about their care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems were in place to demonstrate good governance. This was a breach of regulation 17 (Good governance) 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 17.

- There had been a lack of leadership, direction and oversight. The lack of leadership had impacted on the care people received.
- There was a lack of robust governances, oversight and assurance systems in place which led to significant risks to people's safety.
- During the inspection, we found multiple breaches of regulation. These failings demonstrated the systems to assess, monitor and improve the service were not sufficiently robust.
- Medicines audits had not always been completed regularly to identify errors, concerns and areas for improvement.
- There was no effective system for analysing, investigating and learning from incidents. This failure to conduct effective analyses of incidents meant opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the risk of potential distress or harm.
- Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support, they required.
- The provider's audits had not identified the environmental and infection control concerns which placed people at risk of infection.
- There were no systems in place demonstrating if/how the provider worked with external agencies in order to keep up to date with developments in mental health, dementia care and sensory technology and developments. This would help to ensure care and support delivered was appropriate, in accordance with best practice and drive continuous improvements for a quality, safe service.

We found no evidence people had been harmed however, systems were either not in place or robust enough

to demonstrate good governance. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report.

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

- Throughout the inspection the management team were honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of evidence to show how people and their representatives had been involved in care planning.

Working in partnership with others

- The service did not have robust systems in place to ensure information was shared with health professionals.