Hexon Limited

Rosegarth Residential

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 7 August 2018 and was unannounced.

Rosegarth Residential is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and care for up to 26 older people, some of whom are living with dementia. At the time of our inspection there were 18 people living at the service.

At the last inspection, completed in May 2018, we found that there were six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centred care, the safe delivery of care and treatment, premises and equipment, staffing, recruitment and the overall oversight and governance of the service. The overall rating for this service was 'Inadequate' and the service was in 'Special measures'.

This report only covers our findings in relation to the safe and well-led domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosegarth Residential on our website at www.cqc.org.uk.

At this inspection we found that there were three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, need for consent and the overall oversight and governance of the service.

The service is required to have a registered manager in post. 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. The service had a new manager in post since January 2018, however the previous manager is yet to deregister and the new manager had not started the process of registering with CQC.

Despite the service being rated as inadequate at the last comprehensive inspection the provider had failed to deliver the required improvements to ensure people receive safe care and treatment in line with the fundamental standards.

The service failed to accurately assess the risk to people and ensure that measures were in place to reduce and mitigate this risk. People were exposed to increased risks within the service due to inadequate care provided. People failed to receive adequate support in relation to their tissue viability needs.

People in receipt of covert medicines did not have the required plans in place. Decisions regarding the administration of covert medicines and the use of monitoring restrictions had not been agreed in line with the Mental Capacity Act and through best interest's meetings.

The systems which the provider had in place to assess the experience of people receiving care had not identified the concerns we observed during our inspection. There had been a failure to rectify the failings identified during our last inspection and this meant people continued to receive inadequate care.

The overall rating for this service remains 'Inadequate' and the service is therefore still in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate enforcement action, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

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.

People did not receive adequate care and support to manage the risk of pressure damage.

Risks to people were not adequately assessed, reviewed or updated.

People were placed at increased risk by the service.

Is the service well-led?

Inadequate

The service was not well-led.

Audits and management systems were either not in place or were ineffective at identify concerns. They were ineffective at driving forward improvements.

There was a lack of management and provider oversight.

There was no registered manager in post.

Rosegarth Residential

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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. We also responded to a concern received about the service through the local safeguarding authority regarding the provision of tissue viability care for one person. At the time of the inspection we were aware of third party investigations that were ongoing with the police and the local safeguarding authority whereby a person's tissue viability care and hydration was being considered. The information shared with CQC about these incidents indicated potential concerns about the management of risks of pressure damage, hydration, falls and the environment. This inspection examined those risks.

The inspection took place on 7 August 2018 by two inspectors and was unannounced.

Before this inspection we reviewed the information, we held about the service, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We also considered the action plans submitted by the provider following our last inspection.

During the inspection we spoke with two people who lived at the home, four members of staff, the chef and the regional manager. 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 looked around communal areas of the service and some bedrooms, with people's permission. We also spent time looking at records, which included the full care records for three people, who lived at the service and parts of care records for a further six people, the recruitment and induction records for one newly

recruited member of staff. We looked at other records relating to the management of the service, such as quality assurance and medication.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection, we rated the service as Inadequate in the safe domain. This was because people were exposed to the risk of infection, areas of the premises were unsafe, staff recruitment needed to be more robust, measures to reduce the risk of harm to people were not in place or could not be assessed due to inadequate records and there was a lack of recording of lessons learnt or actions taken following accidents and incidents. During this focused inspection we found that the safe domain continued to be Inadequate. We identified continued breaches of regulation 12 (safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014, with a new breach of regulation 11 (need for consent).

We identified that over a third (seven) of the 18 service users were at risk of pressure damage. However, only two people were receiving 'positional' changes. One person's care plan recorded that they had a grade two pressure sore and required four hourly turns. However, this was not being carried out. Another person required the support of two care staff to change position to manage their risk of pressure damage, however this support was not being provided. For one person who had support to change position, we identified insufficient recording and gaps in support. Another person who received support in this area had contradictory information within their care plan and documentation about the frequency of support required. We observed examples were support was not provided in line with professional advice and staff failed to provide adequate standing pressure relief.

The regional manager demonstrated a lack of knowledge and understanding about how to meet people's needs in this area. We expressed concern regarding the lack of prompting or recording of service users change of positions to enable monitoring and to prevent pressure sores. We also queried whether all service users had capacity to make informed choices about their pressure care relief. The service had not considered these matters in relation to people's pressure care which had led to unsafe practices in this area.

Despite our concerns in this area following our inspection in May 2018 the service had failed to improve its delivery of pressure care to people at risk within the service. The provider had failed to provide training for staff on pressure care management.

The risk to people's tissue viability was increased through the ineffective use of fluid and food monitoring. We observed that where fluid intake was being monitored and totalled there was no target for people to reach. Staff members we spoke with were unaware of what the totals meant and whether and when they would need to take action. The service continued to fail to provide, from our last inspection, an effective tool to monitor and support people's fluid intake. The provider advised us following this inspection that targets were being introduced for people.

The service did not always take action to keep people safe. We identified one person who required a crash mat and sensor matt in place when in bed to keep them safe. Their care plan had failed to be updated to record when this equipment had arrived and been put in place. However, on the morning of the inspection

we found neither matts were in place for this person. This was later found to be in place.

Ineffective risk management plans were in place to reduce the risk of behaviours that may challenge the service for two people. Whilst risks had been identified, guidance for staff on methods to reduce risks were vague and provided little information.

During the inspection the regional manager advised us that no risk assessment for safe access to the garden had been completed, despite this being raised at the last inspection and someone suffering a serious injury in the garden. After the inspection, the regional manager advised us one had been completed on 26 June 2018 and was on display within the service. This was a generic risk assessment for access to the garden. It did not record how individual risks should be managed. In response to our ongoing concerns the provider conducted individual risk assessments for two service users who accessed the garden on a regular basis.

We identified risk assessments in place that were inaccurately completed, inconsistently updated and were not reviewed monthly as required by the providers policy. Risk assessments and care plans continued from the last inspection, to fail to reflect people's current needs. Where reviews had taken place, we identified comments including 'risk assessment is still relevant' when people's needs had clearly changed. For example, one person no longer managed their medication themselves and this was now administered by the district nurses, the risk assessment had not been updated to reflect this. People with health conditions had risk assessments in place that were generic to the condition and gave no specific instructions to staff. Specialist advice from the hospital had failed to be recorded within risk assessments or specific health related plans to ensure effective risk management.

The service had failed to meet one person's nutritional needs and placed them at increased risk in this area. We observed one person received no support with their meal despite this being required as described in their care plan. This resulted in the person not eating their meal on the day of inspection. This person is identified as being 'at risk' of malnutrition based on the most recent nutritional assessment and their weight record documented a recent loss in weight.

Despite concerns raised during our last inspection in May 2018 that care workers lacked knowledge of care plans, three staff spoken with during this inspection confirmed they had not read people's care plans.

Although the service had tried to address our concerns from the last inspection in relation to fire safety we found that the most up-to-date fire risk assessment was still unavailable to staff. We also identified that weekly fire checks did not include people's bedroom fire doors as required by their organisational policy. These ongoing concerns failed to reassure that safe practices had been introduced in relation to fire safety following our inspection in May 2018. After the inspection we were advised that the fire risk assessment had been made available to staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the administration of medicines was safe. We identified two people who received their medicines covertly without covert plans in place. No other concerns were noted with the administration of medicines.

We found covert medicines that had not been agreed through the process of a best interest decision. On speaking with the regional manager, it was established that people with sensor mats in place had not had best interests meetings to authorise the use of those restrictions. The service had failed to demonstrate a

commitment to ensuring that the principles of the Mental Capacity Act were upheld.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection, we rated the service as requires improvement in the well-led domain. There was a lack of effective leadership and management oversight, audits were not robust and did not identify concerns or drive improvements forward. We found a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found a continued breach of regulation 17 and the domain rating is now inadequate.

Following the last inspection, the provider submitted an urgent action plan in response to our initial concerns. This was requested on 18 May 2018 and returned on 25 May 2018. The provider had been working with the local authority quality monitoring team to address the actions raised as part of our inspection. The provider had increased their attendance at the service and the regional manager was temporarily covering the day to day management of the service as a result of the service managers sickness absence. Despite this, there remained a lack of effective leadership and provider oversight at the service which has resulted in significant concerns being identified during this inspection.

The new manager had been absent from the service for around two months. During this time the regional manager was providing daily oversight of the service with the support of other deputy managers and managers from other services under the same provider.

Although the regional manager and covering managers undertook some audits at the service, they had failed to identify the risks we saw during this inspection. The regional manager had completed audits which looked at infection control. However, not all actions identified as part of this audit had been transferred onto the action plan, resulting in these actions not being completed by the time of our inspection. Audits completed on accidents and incidents failed to address our concerns from the last inspection as there continued to be a lack of recording to demonstrate any actions taken or any lessons learnt following incidents and accidents.

Care plans and risk assessments had not been audited and many remained out of date and no longer reflective of people's current needs.

Despite the concerns identified in our May 2018 inspection there has been a lack of oversight of the provision of pressure area care, this had resulted in unsafe care a treatment.

Although the service had introduced mattress checks, these checks failed to include whether the mattresses were set correctly. The correct setting information was not recorded to enable effective checks to be completed. The service was not aware who had been assessed as requiring bed rails. A phone call had been recorded by a covering manager to try and establish from the district nurses who had been assessed as requiring bed rails.

We identified clear data protection concerns during the inspection with confidential information regarding people and staff accessible to all, including people visiting the service. We were also concerned about the

lack of archiving systems in which information could not be located. The provider advised us that the archiving system would be looked at after the inspection; however, this was raised at the last inspection in May 2018 and had failed to be adequately addressed.

Despite the service being rated as inadequate at the last comprehensive inspection the provider had failed to deliver the required improvements to ensure people received safe care and treatment. The systems which the provider had in place to assess the experience of people receiving care had not identified the extent of concerns we observed during our inspection. There had been a failure to rectify all the failings identified during our last inspection and this meant people continued to receive inadequate care. Whilst we recognise that the provider has been reactive to some issues, they continue to be unable to address the concerns themselves without ongoing intervention by CQC.

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

The provider advised us that no residents and relative meetings had taken place since our last inspection. However, one had been planned in the forthcoming months.

The service continued to not have a registered manager in post. Despite discussions with the provider during our last inspection and a meeting with East Riding of Yorkshire Council on 5 July 2018, the registered manager had still failed to deregister, and the new manager had not commenced the registration process with the CQC.

Audits completed by the regional manager had failed to identify two incidents which should have been reported to the local safeguarding authority and CQC. Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are looking at this matter outside of the inspection process.

Previous CQC inspection ratings were displayed within the service; however, they were still not being displayed on their website as required, despite reassurances being given following out last inspection that this would be completed. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are looking at this matter outside of the inspection process.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that decisions had been made in line with the Mental Capacity Act through best interests meetings.

The enforcement action we took:

Notice of proposal to remove the location. This has now been withdrawn.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not adequately managed by the service.

The enforcement action we took:

Notice of proposal to remove the location. This has now been withdrawn.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not picked up on the shortfalls identified during the inspection.

The enforcement action we took:

Notice of proposal to remove the location. This has now been withdrawn.