Rosenmanor Limited

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Inspection report

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Date of inspection visit:
02 September 2022

Date of publication:
06 January 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rosenmanor Limited is a care home providing personal care and support to people with mental health needs. There were eight people living there at the time of the inspection, six of whom were receiving personal care. The service can support up to 12 people.

People's experience of using this service and what we found
The provider's systems to ensure the care people received was good enough were inadequate. The registered manager was also registered as manager at two other care homes which they also owned and they split their time across the services. Our inspection findings showed this system was inadequate as they lacked the necessary managerial oversight of Rosenmanor Limited. They also had a poor understanding of their role and responsibilities. Although some audits were in place these were ineffective as they had not identified or resolved the many concerns we found. In addition, the provider had not notified us of significant incidents as required by law, such as police incidents, to help us monitor the service.

People were not always protected from the risk of avoidable harm. Risks relating to the premises were not always appropriately assessed and some risks to people were not assessed at all. These risks included risk of falls from windows that lacked suitable restrictors; a risk of burns from radiators which were uncovered across the service; a risk of a water borne infection which had not been assessed; an open waste pipe with an open drain which could allow vermin to enter in the dining room; risk of infection or injury from rusty radiators, some of which were crumbling. Some building work looked unsafe or unsuitable including a new office extension where the provider had attached an external wall to the middle of a window in the dining room. Infection control risks were not always well managed. We observed blinds in an en-suite black with dirt. Mops and buckets were stored outside, uncovered and exposed to the elements and creatures. Medicines management was not always safe and the provider could not account for all medicines as procedures to monitor stocks were lacking.

The provider did not always operate safe and effective recruitment practices to ensure staff working with vulnerable people were suitable. The provider did not always obtain suitable references for all staff to check their previous work performance. There were enough staff to support people safely.

People were not always safeguarded from abuse as the registered manager and staff did not fully understand their responsibilities to keep people safe. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. A health and social care professional told us a person had been unlawfully detained since March 2022 as the provider had not ensured legal authorisation to detain them was in place. In addition, the provider had not obtained legal authorisation to administer a medicine to them covertly.

The provider had not ensured people were treated with dignity and respect. Two people had bedroom

doors with glass panels in them which meant anyone standing outside could see inside. The registered manager told us this had been the case since the service re-opened in September 2021 yet they had neglected to act. We found a person had been sleeping on a mattress wrapped in the plastic covering it was delivered on. They told us it they would prefer it was removed and the registered manager had been unaware of this concern. Staff interacted with people in a caring manner and knew the people they were caring for. Care was personalised to meet people's needs and preferences.

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

Rating at last inspection and update
The last rating for this service was good (report published July 2018). The service was dormant following a fire in 2019 until September 2021.

Why we inspected
The inspection was prompted in part due to anonymous concerns received about the standards of care. 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.

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, caring and well-led sections of this full 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 Rosenmanor Limited on our website at www.cqc.org.uk.

Enforcement and recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, recruitment, safeguarding, privacy and dignity, good governance and notifications. 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
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 always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rosenmanor Limited

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.

As part of this inspection we looked at the infection control and prevention measures in place. 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
Rosenmanor Limited 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.

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 was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection including information brought to us by members of the public. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with two members of care staff and the registered manager who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included two people's care records and four staff files in relation to recruitment. A variety of records relating to the management of the service including accident and incident records and audits were also reviewed. We also viewed the premises and gardens.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We liaised with the local authority quality team, the food standards agency, the London Fire Brigade and the Croydon building regulations team to share our concerns about safety. We received feedback from a health and social care professional.

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider had not ensured fire safety was robust, despite a serious fire which closed the service in 2019. The provider took nearly a year to commission a fire risk assessment. This assessment identified several risks and the provider had not met the timescales within their own assessment for resolving these. The London Fire Brigade had been alerted by the local authority and they planned to inspect.
- People were at increased risk of falls from windows as the provider had not ensured suitable window restrictors were in place across the service. The registered manager told us she was unaware restrictors were not in place and confirmed they would be installed the week after our inspection.
- People were at increased risk of burns from radiators as most across the home were uncovered without safety protection. One person was at high risk of falls and we were concerned the risk of them falling against a radiator and not being able to move away had not been assessed. The provider was aware of this risk and confirmed they had arranged for covers to be installed the week after our inspection.
- People were at increased risk from Legionella, a water born infection. The provider had not commissioned a suitable risk assessment nor water testing and controls in place were insufficient. The provider confirmed they had commissioned an assessment after our inspection.
- Some parts of the home were in a poor state of repair/ condition and the provider lacked systems to ensure prompt repairs. This meant the premises were not always safe for people. Several radiators were damaged by visible rust, one of which was crumbling. A toilet had been leaking for two weeks and the provider had not arranged for it this to be resolved successfully. Some areas were affected by damp and a large crack was visible along the floor by the staircase. The garden was uneven and overgrown and littered with piles of rubbish such as old windows and a bath, all of which were unsightly and had not been assessed as trip hazards. The provider told us after the inspection they intended to use the bath as part of a feature in the garden and to build a greenhouse from the windows. An en-suite bathroom was covered with a plastic corrugated roof which was unsuitable. The
exterior wall of the newly built office extension was attached to the middle of an interior window which meant it may not be safe. We reported our concerns to the local authority building control team.

- People were at increased risk of infections from an exposed waste pipe in the dining room from which flowed wastewater from the kitchen into an open drain from which vermin could enter the room. We reported this to the Food Standards Agency (FSA) who asked the provider to cover the drain. This did not affect the providers rating by the FSA.

These risks to people meant provider was breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines management was not always safe. One medicine for one person was missing and the provider could not account for this.

● The medicines trolley was not fixed to the wall when not in use, against best practice, for secure storage.

● Records of medicines administration were signed by two staff instead of one, as advised in national guidance. This meant there was a lack of accountability as to which staff administered and which was the witness. The provider agreed to improve their recoding systems.

● Records of medicines which people took and returned to the home when on social leave were not always recorded. This meant the provider lacked robust systems to monitor stocks of medicines at all times.

● Body maps were not readily available to indicate where creams should be applied to people, although staff were aware of the information.

● Guidelines for the use of 'as and when' medicines were in place but were not always individualised to guide staff on verbal or visual signs a person may need that medicine or whether they would usually ask for it themselves.

● The controlled drugs cabinet was broken. The controlled drugs were not in stock as a person using the was on social leave. However, the provider told us they would replace the cabinet before they returned.

● A person had also been receiving medicines covertly without a clear protocol setting out who had agreed to this and how often this decision would be reviewed. The provider confirmed they had taken the necessary action after our inspection.

These risks to people form part of the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Some parts of the home were dirty. An en-suite bathroom had blinds which were black with mould and dirt. Although a cleaning schedule was in place this had not identified and resolved these concerns.

● Mops and cleaning buckets were stored outside which were visibly dirty. They were exposed to the elements and systems for cleaning and sanitising them were not robust. After the inspection the provider confirmed they no longer stored mops and buckets outside.

These risks to people form part of the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were not always assured that the provider was promoting safety through the hygiene practices of the premises.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

● Records showed the provider had not always considered verbal abuse to be a type of safeguarding and had not reported an incident to the local authority safeguarding team nor CQC as required. The registered

manager told us there were too many incidents to report and then when we challenged this told us it was an oversight.
● Staff told us they received annual training in safeguarding but discussion showed they did not always consider verbal abuse to be a safeguarding matter.
● Several residents told us they were upset by the frequent shouting and abusive language to staff from one person and felt this had not been effectively managed.
● The registered manager did not report a safeguarding allegation made during the inspection to the local authority promptly, following local safeguarding procedures. This meant they did not understand their responsibilities fully.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● A health and social care professional told us a person had been unlawfully detained since March 2022 because the provider had not ensured a DoLS was in place. The provider had not arranged for an emergency DoLS pending assessment of their application, despite being reminded to do so by the local authority.

These risks to people formed a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff recruitment was not always safe. One staff file lacked any references. After the inspection the registered manager sent us two references for this staff member but these were dated after our inspection and both contained the same wording. The reference dates and this duplication indicated the references could not be relied upon and the provider had not thoroughly carried out recruitment checks on staff.

The provider's failure to operate and maintain effective recruitment procedures was a of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● The provider carried other recruitment checks as expected including checks of identification, right to work in the UK and criminal records.
● There were enough staff to care for people safely, although one person told us they would like staff to spend more time taking them outside the home.

Visiting in care homes
The provider accepted visitors to the home in line with current best practice.

Requires Improvement

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect

Ensuring people are well treated and supported; respecting and promoting people's privacy, dignity and independence

● People's privacy was not always respected. Two people had glass panels in their bedroom doors meaning anyone outside could see directly in. When we raised this concern with the registered manager they told us they were supposed to be hallway doors and needed replacing. However, they had neglected to resolve this privacy issue for almost a year. We observed staff did not always knock and wait for permission before entering people's rooms during our tour of the home.

● We checked beds of people who allowed us to enter their rooms. We found for one person their mattress had been left inside the plastic bag it was purchased in. The person told us it was uncomfortable to sleep on and they would like it removed. The registered manager and staff told us they were unaware the bag had not been removed and would ensure this was resolved.

These issues were a breach of Regulation 10 (Privacy and dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to develop their independent living skills such as washing up and doing their laundry. However, one person told us they were limited in doing laundry as only one of the two machines could be used at a time due to the electric sockets. The provider told us they planned to resolve this soon.

● One person told us they would like staff to take them into the community more often. They also told us there was little to occupy them in the home. They also said, "There is nothing to do, all we do is sleep and sleep and sleep, no monopoly, no scrabble, no nothing." Two people told us they were satisfied with the level of activities.

● People told us staff were kind and caring. Staff we spoke with understood people's backgrounds, those who were important to them and their needs and preferences well.

Supporting people to express their views and be involved in making decisions about their care; respecting equality and diversity;

● Staff received training in equality and diversity to help them understood the importance of this in caring for people. People told us their cultural food was included on the menu but they would like more of it.

● People told us they did not have choice of food and the menu showed only one option was available at each mealtime.

● Records showed person had a keyworker who worked closely with them to check their needs were met and that they were involved in decisions about their care.

● Regular meetings were held with people to ask them their views on the service and update them on any changes.

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 good. At this inspection the rating deteriorated 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, understanding quality performance, risks and regulatory requirements

● The provider's systems to ensure the care people received was good enough were inadequate with poor managerial oversight. Although there were some audits in place these were ineffective as they had not identified or resolved the issues we found relating to poor risk assessment of the premises, fire and water safety, risk of falls and burns, recruitment, medicines, safeguarding, infection control, DoLS, privacy and dignity and other concerns set out within this report.

These concerns form a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not always notified CQC of significant incidents as legally required, including, since July 2022, five police incidents and an allegation of abuse. When we raised this concern with the registered manager they told us there were too many incidents to report. When we queried this further, as we disagreed with this reasoning, they then told us this was an oversight and told us they would improve.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

●Our inspection findings showed the registered manager did not fully understand nor meet their role and responsibilities, despite having many years' experience as the registered manager and director. They were also registered to manager two other care homes which they owned and they split their time between all three. Our findings showed this arrangement was ineffective as this service required much more robust management to improve and maintain improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they enjoyed their roles and felt supported by the registered manager.
● Staff knew people well, delivering care day to day in a person-centred way. Staff received training to help them understand people's equality characteristics, such as their mental health conditions and needs related to those. People's care plans reflected their conditions and guided staff on the best ways to meet their

individual needs.
● The registered manager held regular staff and residents meetings to encourage sharing of views, experiences and best practice.
● The provider displayed their current rating in the service as required by law.

Working in partnership with others; 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 provider worked closely with people's mental health care-coordinators. Most people had regular contact with their mental health teams who advised on the best ways to help people maintain good mental health.
● The provider monitored a person whose behaviour indicated distress and liaised with the mental health team for advice on how best to support them.
● People were supported to access other health and social care professionals involved in their care such as GPs, dentists, opticians and hospital specialists.
● The registered manager understood their duty of candour responsibilities.