Rose Cottage RCH Ltd

Rose Cottage

Inspection report

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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

About the service
Rose Cottage is a care home providing personal care to adults living with dementia, and people with physical disabilities. At the time of the inspection there were 13 people using the service. Rose Cottage can support a maximum of 16 people.

People's experience of using this service and what we found
People were not always safe. Medicines were not managed safely. Risks to people were not assessed and managed. Infection prevention and control was not properly adhered to. Lessons were not always learned when things went wrong. There were enough staff to keep people safe.

The service was not always well-led. Governance and systems to monitor quality and safety were not effective. Audits were not always done and did not always identify issues found on inspection.

People were generally positive about the staff that cared for them in the service. Relatives were positive about the care provided to their family member. Staff feedback varied about the service and staffing levels; however they were all complimentary of the manager in post. The service worked with other professionals to benefit the people in the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was Good (published 24 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines, staffing levels and risks to people. A decision was made for us to inspect and examine those risks.
As a result, we undertook a focused inspection to review the key questions of Safe and Well Led only.

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 reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe 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 Rose Cottage on our website at www.cqc.org.uk.

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 monitor the service. 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 medicine management, management of risks, infection prevention and control, good governance at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rose Cottage

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 Care Act 2014.

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
Two inspectors, a medicines inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Rose Cottage 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 did not have a registered manager. The previous registered manager left the service and cancelled their registration in August 2021. A manager was in post and had commenced their registered manager's application. This means, once registered, that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 6 October 2021 and ended on 14 October 2021. We visited the site on 6 October 2021, the other dates were spent reviewing information provided by the service and making phone calls to staff.

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 safeguarding team, commissioners and 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 two people who use the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the provider, the manager, senior care workers, care workers, cook and domestic.

We reviewed a range of records. This included two peoples care records as well as four care records sampled specifically. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, dependency tool and quality assurance records.

Requires Improvement

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 now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely. There was a lack of records around how the home was safely administering and monitoring medication, which put people at risk.
- Allergy information was not available on medication administration records.
- There were no 'as and when required' protocols in place, for how to administer medicines prescribed to be given as and when people required them.
- Safe storage of medication was not monitored by temperature checks.
- The supply and administration of a medicine to one person to support with behaviours that challenge was not documented.
- Medicines audits were completed, and issues were identified in these. However, there was no evidence of lessons learnt or action plans to rectify the issues.

We found no evidence that people had been harmed however, systems were not in place to ensure medicine management was safe. This place 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.

The provider responded during and after the inspection. They confirmed actions had and were being taken to address the risks.

- Arrangements were in place to help ensure that medicines prescribed to be taken 'before food' were given at the appropriate times.
- Systems were in place to ensure medicines were ordered, received and disposed of appropriately.

Assessing risk, safety monitoring and management

- Risks to people was not always managed safely. One person's care record had not been updated appropriately after significant events and they did not have a behaviour plan in place. Therefore, there was no information for staff about what action they should take to support the person in times of behaviours that challenge, and to keep others safe.
- Nutrition records were not detailed to show amount of food consumed. There was no detail in relation to the fortification of the food so monitoring this for weight loss was not achievable.
- Where people had lost weight and were nutritionally at risk, we saw no evidence of weekly weights being completed.

We found no evidence that people had been harmed. However, risks associated with people's care were not always assessed and managed which 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.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections.
The home had systems in place to carry out COVID-19 tests and checks when visitors arrived at the care home. However, during the site visit, two of the inspection team were not asked for their later flow tests.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
The home had cleaning schedules in place and isolation procedures however, there was only one domestic staff member employed during the day who was not available every day. We identified when the domestic staff member was not on shift the care staff often did not do the cleaning.

Following the inspection the provider confirmed a member of the night staff cleaned throughout the night.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
The home does not have a full-time domestic team. On the day of inspection there was no domestic staff. We observed no cleaning taking place, high touch areas were not done.

● We were somewhat assured that the provider was using PPE effectively and safely.
The home had a good supply of PPE and staff were observed to be wearing PPE throughout the day of inspection. However, on multiple occasions staff were not wearing PPE correctly. For example they had their mask below their nose, and were not all bare below the elbow.

We found no evidence that people had been harmed. However, risks associated with infection prevention and control was not always assessed and managed which 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.

● We were assured that the provider was meeting shielding and social distancing rules.

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

● We were assured that the provider was accessing testing for people using the service and staff.

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● Systems protected people from potential abuse and neglect. The provider reported safeguarding concerns to the local authority and investigations were carried out when people were harmed.

● Staff had received safeguarding training and knew how to recognise and protect people from the risk of abuse.
● The manager and staff understood their responsibilities to safeguard people from abuse.
● People felt safe. One person said, "I feel safe, I am alright here". Another person told us "Nobody will do me any harm." They told us another person used to enter their room but they have put a gate on the door to stop this happening. Relatives also told us they felt people were safe.

Staffing and recruitment
● There were enough staff to keep people safe. The manager said they were recruiting another four staff members to ensure safe levels of staff were available throughout the winter.
● Feedback about staffing levels was mixed; some staff said arrangements worked well, some others felt they needed more staff to ensure there was always someone with the people. One person said they had to "wait a while for their buzzer to be answered" and they felt the home needed more staff at certain times. On inspection we observed adequate staffing levels.
● Staff recruitment was safe. Recruitment checks were carried out before staff commenced work, with references obtained.

Learning lessons when things go wrong
● A monthly analysis of accidents and incidents was completed which helped identify themes and trends. However, there was no effective arrangement in place for learning when things when wrong
● Complaints to the service were managed appropriately but there was no analysis evident to suggest lessons were learnt.
● Staff and relative meeting minutes showed managers were responsive to suggestions for improvements within the service.

Requires Improvement

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 this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a registered manager. A manager was in post and had commenced the registration application process. They said they felt supported in their role.
- Governance systems were in place but not always effective. The manager's quality audits for medication, risks, infection prevention and control were effective at identifying issues, however there was no follow up or action plan to rectify the issues.
- Care plan audits and updates had not identified that fortification and nutrition were not being adequately documented and monitored. Where people had lost weight, the requirement was for weekly weight checks to be completed. The audits did not identify the weekly weights were not being completed.
- Audits on care plans and risk assessments had not identified discrepancies in the online system which meant parts of the care records were not kept up to date.

We found no evidence that people had been harmed, however systems and processes were either not in place or robust enough to demonstrate good governance. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to address the quality of the governance systems.

- The manager had made a good impression on the staff team. One staff member said "[Manager], is fantastic, she is making a difference."

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

- People who lived at the service and their relatives spoke positively about their experience of living at Rose Cottage. During the inspection we observed a warm and inclusive atmosphere in communal areas of the home.
- The manager had been proactive about getting in touch with relatives and other stakeholders. Relatives feedback about the new manager was good. One relative said, "The communication has remained good even though there have been changes in staff."

● Staff spoke enthusiastically about the home and the provider. They felt supported in their role. One care worker said, "We work as a team now and help each other."
● The provider had not carried out surveys this year to seek people's views. Their process is to do this at the end of the year. However, the service kept in regular contact with relatives. One relative told us, "Communication is fantastic, we are kept up to date with what activities are going on and can ring up at any time".

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
● Registered providers are legally obliged to inform CQC of certain incidents which have occurred within the home. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. The provider understood the duty of candour and kept people and relatives informed about key changes within the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People gave positive feedback about the care they received. Comments included, "I like it here, it is quiet, and I get on well with all the staff. They look after me well and I get my meals on time".
● Staff meetings were held to discuss performance issues and consistency in approach, such as completing medication audits, cleaning, correct procedure to report concerns. There was an opportunity for staff the share their views.
● Relative meetings were held. The minutes demonstrated people were involved in making decisions about the service and how to continue to improve communication. For example, relatives requested a chat group to share information and updates on the home. This was implemented immediately.
● The service had received positive feedback from relatives, complimenting and thanking staff for the care provided. Records showed relatives were kept informed of events and care needs.

Continuous learning and improving care
● The provider had robust systems in place for audits, inclusive of actions plans for the manager. However, despite identifying concerns these were not always actioned or rectified.
● Throughout the inspection the provider and the manager were responsive to feedback. They demonstrated commitment to improving the service.

Working in partnership with others
● The manager was working with the GPs, telemed services, district nurses, clinical commissioning group (CCG), and safeguarding teams.