Achieve Together Limited

Rosebank Lodge

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

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Rosebank Lodge is a residential care home. It was registered to accommodate and provide personal care and support to 13 people with learning disabilities or autistic spectrum disorder. At the time of our inspection 10 adults aged between 30 and 65 with mild to severe learning disabilities or autistic spectrum disorder lived at the care home.

People's experience of using this service and what we found

Right Support
Staff did not support people to have the maximum control over their own lives. Staff did not do everything they could to avoid restraining people. The service failed to record when staff restrained people, and staff did not learn from those incidents and how they might be avoided or reduced. Governance processes were not always effective in providing good quality care and support.

Right Care
Staff did not always understand how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse, however, did not always apply it. Staff spoke positively about the people they supported.

Right culture
People experienced harm because of a lack of protection, they experienced or were at risk of abuse, including unnecessary restraint, segregation and seclusion. The service had a closed culture whereby people were not supported to live safely and free from unwarranted restrictions because the service failed to adequately assess, monitor and manage safety well. Staff did not respect people's rights. There is a lack of visible leadership, staff were reluctant to report incidents, and management failed to act on known issues.

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

Why we inspected
The inspection was prompted in part due to concerns received about people being unlawfully deprived of their liberty. A decision was made for us to inspect and examine those risks

We have found evidence that the provider needs to make improvements. 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.

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 have identified breaches in relation to people's need to consent, safeguarding service users from abuse and improper treatment, good governance and notification of other Incidents 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.
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rosebank Lodge

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
Rosebank Lodge 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 that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection the registered manager was on leave.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed the information we held about the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
People who use the service were not able to tell us of their experiences verbally so we observed their interactions with staff. We contacted seven and spoke with two people's relatives about their experience of the care provided. We spoke with seven members of staff including care workers, two area managers and operations director.

We reviewed a range of records. This included four people's care records and three medication records. 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 training data and behavioural support plans. We spoke with one professional to gather their views of the service.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; and Ensuring consent to care and treatment in line with law and guidance

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 MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- People were being deprived of their liberty unlawfully.
- Prior to the inspection we were informed of incidents whereby staff were locking people in their bedrooms without the necessary skills to open the door independently; and staff turned off people's water supplies in their room to ensure they could not flush items down the toilet or cause a flood.
- Staff told us that people were locked in their bedrooms so that they did not walk into other people's rooms causing distress. Deprivation of Liberty Safeguards (DoLS) written authorisations in place did not authorise the use of such restrictive practices.
- Senior management were unable to access up-to-date records in relation to people's DoLS applications and their status. Therefore, we could not be assured that DoLS had been applied for in a timely manner.
- At the time of the inspection the local funding authority confirmed the service had not reapplied for DoLS authorisations.
- People were at risk of abuse as the service had an embedded culture whereby staff members were unable to identify, escalate and report poor practice.
- On the first day of the inspection we observed staff unlawfully restraining one person. The staff member had failed to use de-escalation techniques and used physical restraint as a first response instead of a last resort. The staff member was unclear on how to safely support the person who was attempting to leave the service without direct support from staff.
- Incidents of physical restraint were not documented, which meant healthcare professionals were unable

to accurately assess their needs as they did not have a clear evidential history of the behaviours people engaged in.
● On the second day of the inspection, the area manager informed us that she had located 53 incident and body map documents which had not been reported to the local authority nor thoroughly investigated to minimise repeat incidents. The incident forms were not completed appropriately and had not all been reviewed by senior staff to identify patterns and trends in order to prevent reoccurrence.

The provider failed to ensure people were protected from avoidable harm and deprived people of their liberty unlawfully, these issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Need for Consent.

● The area manager told us as soon as they were alerted to the restrictive practices they removed all locks from people's doors who were unable to open the door from the inside of the room.
● The area manager arranged for safeguarding training for all staff to ensure they were familiar with identifying, responding to and escalating suspected abuse.
● At the time of the inspection there was one safeguarding incident being investigated by the local funding authority.
Assessing risk, safety monitoring and management
● People were at risk of avoidable harm as risk assessments were not always effective in managing potential risks to people. We reviewed the risk management plan for one person that stated they were at risk of choking when eating. However, there were no specific clear steps for staff to follow in order to respond safely should this occur.
● Risk management plans were not reviewed in line with the provider's review dates. The management plans did not reflect people's current needs and there was a risk that people were at risk of receiving unsafe care.
● We reviewed one person's risk assessment with reference to them engaging in behaviours they exhibit when anxious, distressed and overwhelmed. The risk assessment was unclear and did not give staff adequate guidance on how to effectively meet their needs whilst initiating de-escalating techniques.
● We shared our concerns with the area manager who submitted an updated risk assessment however, this was not as clear as it could be and was at risk of being misunderstood by staff.

The provider failed to ensure people received a safe service, these issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safeguarding service users from abuse and improper treatment.

● After the inspection the area manager sent us updated risk assessments in relation to the person who was at risk of choking. These risk assessments had been undertaken by the in-house behavioural specialist and were comprehensive and robust. They detailed the identified risk, assistance required, environmental factors and risk mitigation measures to be used.
● We will continue to monitor how the area manager progresses with the risk assessments.

Using medicines safely
● People did not always receive medicines that were managed safely. Records for two people stated that they were not administered medicines, however their medicines administration records [MAR] stated that they were prescribed 'as required' [PRN] medicines.
● One person's homely remedies chart stated the administration of a hay fever medication, however the same medication was not to be taken by people with a specific diagnosed condition that the same person had. There was a risk that the person could be given a medicine with contra-indications that could have had

an adverse effect on their health.
● We shared our concerns with the area manager and operations director who told us they would review people's medicines 'homely remedies' forms and update them accordingly.
● Despite the findings above, staff told us should they identify a medicines error, they would document it and report it to the area manager immediately.
● People's medicines were stored securely and Medicines Administration Records (MARs) were completed accurately.

Staffing and recruitment
● People received care and support from sufficient numbers of staff.
● The provider had systems in place to ensure all employed staff underwent robust recruitment processes to ensure their suitability for the role.
● There were sufficient staffing levels to ensure people could attend and participate in activities both in house and in the local community as they wished.
● Despite our findings, relatives commented, "Quite often staffing numbers can be an issue", and "A lot of the time no, there aren't enough staff. They appear to be run off their feet. Sometimes there is no one to answer the phone."
● We reviewed staff personnel files and identified these contained an application form, employment and education history, satisfactory references, photographic identification and a Disclosure and Barring Services check (DBS). A DBS supports employers to make safer recruitment decisions. Staff provided their full employment history, as well as explaining any gaps. Staff records showed that appropriate employment references were sought prior to commencement of work.
● On the second day of the inspection, the area manager and operations director told us they had increased the one to one support specific people received to keep them safe. They had requested the local funding authority complete a review of people's needs to ensure the level of support appropriately met their needs.
● Staff told us there were enough staff throughout the day and night and that the use of familiar agency staff ensured they were at a full compliment.

Learning lessons when things go wrong
● People did not receive a service whereby lessons were routinely learned when things went wrong. Records showed the registered manager had failed to keep accurate and robust records of people's behaviours and incidents and accidents, to ensure lessons could be learned.
● After the inspection the area manager had taken action to address some of our concerns, including the implementation of a review of the recording systems, involvement from internal specialists in behavioural management and health and safety. We will continue to monitor the progress of the service.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.

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 this key question has now 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.

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

- The registered manager had failed to adequately understand their role and responsibilities under their regulatory requirements.
- The registered manager had failed to submit notifications of reportable incidents to the CQC. During the second day of the inspection, the area manager told us they had located 53 additional body maps indicating there had been incidents whereby people had sustained an injury, dated between 2019 and the inspection. These incidents had not been appropriately recorded, investigated or submitted to the relevant healthcare professionals. This meant any trends or patterns were not robustly monitored to minimise repeat occurrences.
- Incidents whereby staff members engaged in physical restraint or whereby staff deprived people of their liberty, were not clearly recorded or analysed.
- Risk assessments were not robust and failed to give staff clear guidance on how to keep people safe, for example, people who were at risk of choking and those that engaged in behaviours that demonstrated anxiety or distress.
- During the inspection we identified incidences whereby people who were previously subject to a standard DoLS authorisation, were not in receipt of a current authorisation. The area manager informed us they had been in contact with the local funding authority to ascertain who was in receipt of an active and in date DoLS authorisation. However, when we spoke with the local authority, they confirmed no new authorisations had been requested or submitted for their consideration.
- We requested to see the audits the registered manager had undertaken to monitor the service provision; however, these were not provided.

The provider had failed to ensure people received a service that was well-led. These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance.

The provider failed to notify the CQC of reportable incidents. These issues are a breach of the Care Quality (Registration) Regulations 2009 - Regulation 18 - Notification of other Incidents.

- After the first day of the inspection the provider had increased the senior management presence within the service, to drive improvements and provide staff with consistent guidance.
- A healthcare professional told us, "Our biggest concern is how much support is the home getting from senior management and once things then improve, [and the senior management are no longer present]

issues will potentially escalate."
● The area manager arranged for all staff at Rosebank to receive training in safeguarding and Positive Behaviour Support as a matter of urgency.
● After the inspection we requested an immediate action from the provider in response to our concerns. The area manager submitted an action plan detailing the action they would take to improve the service and by when. We will continue to monitor their progress.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People received care and support from a service that had an embedded closed culture amongst the team working within the service. This had led to the recent identification of poor practice amongst the senior management team and our inspection.
● Comments from relatives received included, "I would probably [take my relative] somewhere else if I could", and "I think they [staff members] do what their statutory obligation is and no more."
● Staff reported a positive environment that meant that teamwork and co-operation with colleagues was consistent. However, recent findings had meant senior management had identified the need to retrain all staff to ensure they did not operate restrictive practices.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives were not asked to share their views consistently.
● Feedback received included, "I think the communication at Rosebank is very poor. The staff struggle to communicate, and no information is voluntarily given", and, "I haven't been asked to complete a questionnaire for years. They will do a yearly review which I will share my views."
● Despite the above comments relatives told us there had been an improvement since the area manager was present in the service.

Continuous learning and improving care and Working in partnership with others
● The registered manager did not undertake robust auditing of the systems and governance and it required our inspection to highlight the shortfalls.
● The registered manager failed to consistently work in partnership with healthcare professionals and implement their guidance into the care provided. For example, where someone had been identified as at risk of choking, guidance from the healthcare professional had not been recorded in the person's risk assessment.

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 senior management team understood their responsibilities under the duty of candour, and the need to apologise where things went wrong. Where senior management had recently identified the serious errors in locking people in their rooms, they had liaised appropriately with people's families and advocates.
● The management team recognised the areas that required improvement amongst the service and had developed an immediate, comprehensive action plan; as well as taking on board feedback from our inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of reportable incidents. These issues are a breach of the Care Quality (Registration) Regulations 2009 - Regulation 18 - Notification of other Incidents.

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 failed to ensure people were protected from avoidable harm and deprived people of their liberty unlawfully. Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Need for Consent.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people received a safe service Regulation 13(1)(2)(3)(4)(b)(5) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safeguarding service users from abuse and improper treatment.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems in place monitored the service to drive improvements. Regulation 17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance

The enforcement action we took: