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Rock Cottage Care Services

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service: Rock Cottage is a 36-bedded residential care home that was providing personal and nursing care to 32 people aged 65 and over at the time of the inspection.

People's experience of using this service:

The service had deteriorated in some areas since our last inspection.

People received their medicines safely. However, we found that protocols and risk assessments for specialist as and when medication was lacking.

Staff were not effectively deployed. People told us that although staff treated them with kindness, there were not able to spend time with them that was not related to a care task. We recommend that the provider source a dependency tool to inform their staffing levels.

People's support needed were planned and assessed for, however they lacked person centred detail and management of risks to people required strengthening.

Although the service was working within the principles of the Mental Capacity Act (2005), awareness around completing capacity assessments and completing best interest decisions needed strengthening. People had access to healthcare professionals.

Governance systems were not being applied consistently meaning that the services people received were not always effectively monitored.

People were supported by safely recruited staff and protected from potential abuse. Staff knew people well and the registered manager was approachable.

The previous inspection rating was displayed in the service.

Rating at last inspection: Requires improvement (19 January 2017). This service has been rated as requires improvement at the last two inspections.

Why we inspected: This was a planned inspection based on the previous rating.

Follow up: The next scheduled inspection will be in 12 months. We will continue to monitor information that we receive from and about the service. We may inspect sooner if we receive concerning information about the service.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Rock Cottage Care Services

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is dementia care.

Service and service type:

This service is a residential care home that provides personal and nursing care to older adults. People who use the service may have physical disabilities and/or mental health needs such as dementia.

'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.'

Notice of inspection:

This was an unannounced inspection and took place on the 5 February 2019.

What we did:

We used information we held about the service to plan our inspection. Prior to the inspection the service sends us a Provider Information Return (PIR). This is information we require providers to send to us when we request it to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service such as notifications. A notification is information about events that happen at the service and the registered persons should tell us about by law.

We contacted Staffordshire local authority and Staffordshire Healthwatch to gather their views of the

service. Healthwatch helps people speak up about health and social care services in the Staffordshire area.

During inspection we spoke to seven people using the service and three relatives, two staff members, one volunteer, the registered manager and provider. We also spoke to one healthcare professional. We looked at three people's care records and viewed medication records. We looked at two staff recruitment files and accident and incident records. We also viewed documents that showed how the service was managed such as audits and training records.

Is the service safe?

Our findings

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

During our previous inspection on 19 January 2017 we found that the service was not consistently safe and some improvements were needed to ensure that medicines were consistently managed in a safe way. At this inspection we found 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.

Assessing risk, safety monitoring and management

- People's clinical needs were assessed and planned for. This included risks associated with mobility and health conditions. Some people had health conditions which meant they could not tell staff when they were in pain and required staff to observe for non-verbal signs of discomfort. However, there was no guidance for staff as to what these non-verbal signs were. This meant people were reliant on individual approaches from staff to ensure they received pain relief when in pain.
- Staff were familiar with people's needs and how to manage risks. However, the guidance for staff to follow in relation to reducing people's known risks lacked detail and meant that people were at risk of receiving inconsistent care and support. For example, one care plan said when a person was agitated and unsettled they needed one to one support, but it gave no details as to what this support should consist of.
- Appropriate strategies to reduce people's known risks were not always implemented or followed by staff. For example, one person had experienced a high number of falls since their admission and the approach of staff to reduce this risk of falls was not working successfully in the home. The ability of staff to support this person to reduce their risk of falls was impacted upon by the availability of staff in the home. The registered manager had identified this risk and was liaising with the other professionals involved in their care however, effective strategies to protect the person had not been implemented.

Using medicines safely

- Some people had thickener which was kept in their rooms, meaning that other residents could access this and come to harm if they ingested it. We spoke to the registered manager about this and advised they read the NHS patient safety alert in relation to 'Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder.'
- As required (PRN) protocols were in place for some medications; however, protocols and risk assessments were lacking for specialist medication, for example diabetes. This is important information for staff to have, particularly if people cannot communicate their needs.
- People's prescribed creams were not being managed in accordance with the NICE guidance for managing medicines in care homes. We found that creams being stored in the fridge had no open date on them. This meant that people could be given medication that was past its use by date as staff would not know when they had been opened.
- Stock levels were correct for medicines and controlled drugs and they were kept safely in a locked room.
- People told us that they received their medicines as they should. With one person telling us that if they are in pain they would tell staff and would be offered painkillers.

Staffing and recruitment

- People could not be assured that sufficient numbers of staff would be available to provide their care in a timely manner. Staff were not always deployed effectively to meet people's needs. For example, to supervise a person who was at risk of falls. The provider did not have a system to calculate the number of staff that were needed to work in the home based upon people's assessed care needs.
- People told us that, "Oh yes, they can't always deal with me immediately on the clock, for instance they have to come back if they need two of them, that's what they do." Another person told us, "No, there aren't enough staff they're run off their feet, they're really caring people but always on the run to someone else and it's a shame."
- We recommend that the provider source a dependency tool to inform their staffing levels and undertake a review of the levels of staff required to work in the home to provide people's care in a consistently timely and personalised manner.
- People received support from safely recruited staff. The records evidenced that references had been sought and Disclosure and Barring Service (DBS) checks had been completed to ensure that potential staff were of good character to be able to work with people who used the service. The DBS helps employers make safer recruitment choices.

Preventing and controlling infection

- People told us that staff wore personal protective equipment (PPE) such as gloves and aprons. Family members also told us this and we observed staff wearing PPE when carrying out specific tasks, for example serving and supporting people with their food.
- Staff told they had received training in infection control and we saw the up to date training records that confirmed this.

Systems and processes to safeguard people from the risk of abuse

- People were protected from potential abuse.
- All the people we spoke to said that they felt safe. One person told us "No worries about safety duck, I'm all right here - better than at home."
- Staff had received safeguarding training and knew their responsibilities and how to report concerns.

Learning lessons when things go wrong

- The registered manager had a system in place to record and analyse accidents and incidents and made referrals to appropriate professionals as necessary. For example, the registered manager made a referral to the GP for a medication review, following a person experiencing a number of falls.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection in January 2017 we found people's outcomes were consistently good, and people's feedback confirmed this. During this inspection we found the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to admission to the service to ensure that the home was able to accommodate people's care and support needs prior to them being admitted. However, these pre-assessments lacked person centred detail and did not consider any protected characteristics. Protected characteristics were introduced by the Equality Act 2010
- Following our feedback, the registered manager told us that they would review their preadmission assessments to ensure that they adequately considered people's holistic needs including interests and protected characteristics.
- Care plans were in place for people that detailed the support they required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People received support from relevant healthcare professionals.
- One person told us that the doctor regularly visits the service, with another resident telling us, "The Chiropodist comes frequently [but] I'm not certain how that works. [If I want to see] the Optician I just have to ask."
- Where guidance was offered by healthcare professionals, it was not always followed. For example, a healthcare professional had recommended that staff utilise sensory stimulation and distraction techniques to ease one person's anxiety. However, they advised us that these recommendations had not been implemented by the home.

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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- We found that the provider had applied for DoLS, however the application of these requirements in the

home was not consistent. People's capacity to consent to their care had not always been assessed prior to a DoLS authorisation being sought and capacity assessments were not always decision specific.

- People were supported by staff who were aware of the principles of the MCA. One staff member told us, "You can't just assume someone hasn't got capacity [it is about] not making decision for them and allowing to make decisions for themselves."
- We saw documents that asked for the signature of the person's next of kin, this is not in line with the MCA. We spoke to the registered manager about this who stated that they would change the documentation to reflect this.

Staff support: induction, training, skills and experience

- People were supported by suitably trained staff who had received training relevant to their role.
- People told us that, "Every one of them [staff] have been brilliant. With one relative saying, "They [staff] seem to know what they're doing with them [people] and most of the staff have been here a long time now."
- Staff told us they felt supported by the registered manager, with one saying, "if I feel there is something I am unsure about [training] then they will look at getting training in place."

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain good nutrition and hydration.
- On person told us, "The food is very good. If you didn't like that something you can speak to chef and they will do you something else."
- Care plans were in place that detailed people's dietary needs. For example, on person required their food pureed and their drink made with thickener. We observed that they were given this, in line with their care plan.

Adapting service, design, decoration to meet people's needs

- People were supported to personalise their room with their own belongs.
- We saw that there were signs around the building directing them to certain areas, like the lounge and dining room.
- There was a conservatory but this was closed with the provider informing us that they would be having a new one installed soon.

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 our last inspection in January 2017, we found people were supported and treated with dignity and respect; and involved as partners in their care. During this inspection people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

- Staff were committed to treating people with kindness and compassion; however, staff did not always have the time to spend with people and talk. This impacted upon the ability of staff to have consistently caring interactions with people.
- One person told us, "Yes, they treat me well – we have a chat when they come around but they haven't got time to stop and chat."
- Staff also told us that they were not able to sit with people and have a conversation. The approach of staff was often task focussed and their ability to having meaningful engagement with people outside of the time spent providing personal care was limited.
- People had some of their protected characteristics, such as religion considered. The registered manager informed us that members of religious organisations visited regularly to see people. However, other protected characteristics had not been considered, meaning that people may not be fully supported in this area.
- People told us their preferences were listened to and respected. For example, one person did not want to eat their dinner in the dining room and chose to eat it in the lounge and this has been accommodated for them.

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

- People being asked for their feedback about their care was limited. The registered manager informed us they were in the process of designing a new feedback questionnaire.
- We asked people if they felt that the service involved them in making about their care. The response we received was mixed, with one person telling us, "They just tell me." Another person told us that "The only time the registered manager would come in and ask me to sign for certain things, especially about this palliative care and one or two other things they ask me to sign for, but the registered manager explains what they are."
- People told us that information was given to them in a way that they could understand.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was promoted and respected by staff.
- All the people we spoke to told us that that their privacy and dignity was upheld and staff were respectful to them.
- One person told us that the service promoted their independence, "I [person] need all this stuff around me or I'd be calling all the time but it's all where can reach it easily now."

- A relative told us that their family member was not walking when they were admitted to the service but had now regained that ability.
- Staff could give us examples of how they respected people's dignity such as making sure people's modesty is maintained when undertaking personal care by covering the area up they aren't supporting with.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection in January 2017 we found people's needs were met through good organisational delivery. During this inspection we found people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People did not always receive personalised care that was responsive to their preferences or interests.
- People's care plans lacked detail about their personal history, staff did not always know their interests so could not respond accordingly.
- Although the service had an activities coordinator, people told us that, "I used to do more at the previous care home where they used to get me involved. I used to do all the posters for them but not so much here."
- Another person told us that there was not much to do during the day, however the activities coordinator was "Very good at getting you to do things. Sometimes they [activities coordinator] will arrange it if you can't move very well will organise exercise like throwing the ball. [Activity coordinator] is creative, helps us make cards. We are lucky to have [activities coordinator name]."
- The activities coordinator worked part time and outside of the time they were present in the home staff did not have the time or resources to provide meaningful activities or stimulation for people. The home had volunteers that spent time with people however, the provision of activities and the systems used to support people to pursue their interests needed strengthening.
- Care plans were reviewed regularly; however, we did not see people were involved in these reviews with on relative telling us that they have "Never been approached but the office is always open to go in."

Improving care quality in response to complaints or concerns

- There was complaints process in place, should people wish to complain.
- People told us that they felt able to complain, with one person telling us "'Oh yes, I'd talk to any of them really, they're very accessible and the carer would find the right person to see to it [the complaint]."
- On relative told us that they had raised two issues with the provider and both were seen to quickly.

End of life care and support

- The registered manager informed us that there was nobody imminently near end of life at the time of our inspection. The service did have an end of life care plan but not being used effectively and did not focus on the wishes of how the person wanted their end of life experience to be.
- There was not proactive planning of the care people required at the end of their life. The manager told us that they developed these plans once people required palliative care however, this meant that there were missed opportunities to consider people's preferences and wishes.

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 in January 2017 we found further improvements were needed to ensure that systems in place to consistently assess, monitor and improve the quality of care were effective. During this inspection we found service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

- The systems and processes in place were not effective in monitoring and improving the care people received.
- This was the third inspection in a row where the service has been rated as requires improvement.
- The providers governance systems were not effective in monitoring and improving key aspects of people's care. For example, we found that people's known risks were not always consistently reduced. One person's care planned stated they required staff support at all times. However, staff told us that did not happen due to lack of staffing.
- We also identified a lack of protocols for specialist as and when medication had not been identified by the providers own systems.
- Although the provider was working within the principles of the MCA, processes were not in place to ensure there was a consistent approach to applying for DoLS applications. Additionally, systems did not identify that mental capacity assessments and best interest decisions were lacking.
- People's dependency needs were assessed but this information was not used effectively as there was no dependency tool used, which would enable them to assess staffing level more accurately based on people's needs.

The above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The providers systems did not ensure people received person centre care which reflected their preferences.
- Although care plans were reviewed and risks to people highlighted, no action was taken to mitigate these risks. For example, one person was nursed in bed and a risk of social isolation had been highlighted, but no further consideration had been given to how to lessen this risk.
- Staff were clear about their roles and responsibilities.
- There was a will and commitment from the provider to improve aspects of the service, however there was no clear strategy in place for this.

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

- People told us they knew who the registered manager was and that she was helpful and approachable. One person told us, "Yes, [the registered manager] comes every day, [registered managers name], that's the boss."
- People also told us that they could speak with staff if there was anything they wanted to discuss.
- Staff informed us that the registered manager was supportive. With one staff member telling us that "The [registered manager] is exceptional. You can tell them anything and they will help you."

Continuous learning and improving care

- People being asked for their feedback about their care was limited. The provider had produced a questionnaire asking for feedback, however very few people or relatives had completed the questionnaires. After the inspection the registered manager sent us an action plan, which included researching and producing a new customer satisfaction survey.
- Staff told us that the training they received to support people was "Spot on" and the registered manager was "Very good with training."

Working in partnership with others

- The service worked in partnership with other organisations with health professionals, including the GP and other health professionals. The service also employed their own occupational therapist.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems were not always in place or were not always effective at identifying when improvements were required.