Autumn Days Care Limited

Rosedale Retirement Home

Inspection report

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01 November 2021
04 November 2021
24 November 2021
02 December 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Rosedale Retirement Home is a residential care home providing personal care for up to 24 people aged 65 and over in one adapted building. At the beginning of the inspection there were 20 people who lived in the home, by our final inspection there were 17 people living in the home.

People's experience of using this service and what we found
Staff did not recognise different types of abuse and how to report it. The previous manager had not understood their safeguarding responsibilities and how to protect people from abuse. The new manager had a good understanding of their safeguarding responsibilities. Potential risks to people's health and wellbeing had not been identified to ensure these were managed safely. People had not been involved with decisions in how to reduce risk associated with people's care and people told us they did not feel listened to. There were not sufficient staff on duty to keep people safe and meet their needs. People's medicines were not managed and stored in a safe way. Safe practice was not consistently carried out to reduce the risk of infection.

People's care needs had been assessed and reviews had not taken place with the person and where appropriate their relative. Staff had not received the training and support to be able to care for people in line with best practice. People were supported to have a healthy balanced diet and were given food they enjoyed. Staff did not work with external healthcare professionals to follow their guidance and advice about how to support people following best practice. The new nominated individual and manager were working to improve these external professional working relationship links. People had not been 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 support this practice.

People were supported by staff who treated them with kindness, however, there were not enough staff to support people which compromised people's dignity. The environment of the home did not promote people's independence or privacy.

The provider could not be assured people's care was delivered in a timely way, with any changes in care being communicated clearly to the staff team. There were actions being taken to improve staff communication, so management had a clear understanding of people's experiences of care and whether additional input was required. People were not supported or encouraged to maintain their hobbies and interests that were individual to them. People did not have access to information about how to raise a complaint and did not feel listened to. The providers system for receiving complaints to enable them to respond to these was ineffective. The provider could not be assured people's end of life care needs had been met in line with their preferences in a respectful and dignified way.

Significant management changes had taken place during the period of this inspection. We received mixed reviews about the management of the service, However, the provider could not demonstrate they had

always listened to people and strived to achieve the best possible improvements to the home and the way the service was run. The providers checks to monitor the quality of the service provision were inadequate and had not identified or acted upon the significant concerns we identified on inspection. The provider recognised the seriousness of our concerns and took action to mitigate immediate risk. It was recognised by the provider that time would be needed to return Rosedale to its prior good ratings.

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 requires improvement (published 27 September 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. The inspection was also prompted in part due to concerns received about people's care. 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, Effective, Caring, Responsive and Well-led sections of this full report. Where we identified significant concerns, the provider took action to mitigate risk.

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.

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 Rosedale Retirement Home 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 people's management of risk, staffing, recruitment, infection control, person-centred care and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns can be found at the end of this report.

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.

Special Measures
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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rosedale Retirement Home

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
On 01 November an inspector and inspection manager visited the service. On 04 and 25 November and 02 December 2021 two inspectors visited the service.

Service and service type
Rosedale Retirement Home 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 however they were no longer employed by the provider. 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
The 01 November, 25 November and 02 December 2021 inspections were unannounced.
The 04 November 2021 inspection was announced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 seven people who used the service and two relatives about their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 15 members of staff including the three provider representatives, the nominated individual, a member of staff from a specialised consultancy service, two managers, five care workers, an agency care worker, two cooks and the maintenance person.

Following the 04 November 2021 inspection significant changes of staffing had taken place. The manager from 01 and 04 November 2021 inspection visits had left, along with two care staff and the cook. The nominated individual also changed following this inspection and a new manager was recruited. 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 people's care records and multiple medication records. We looked at staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, recruitment records and quality assurance records including environmental and fire safety checks. We spoke with one professional who regularly visited 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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people, have safe medicine management in place and assess the risk of, and preventing, detecting and controlling the spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.
- We identified areas of concern for people's safety when staff assisted people with their physical needs including using equipment, skin care, dietary requirements, and how staff were to support people in the event of a fire.
- People were placed at potential risk of unsafe care as their care needs and associated risks had not been routinely assessed, monitored and mitigated. In care records we reviewed, there was little to no information about what or how people were to be supported. In some people's records information was historic and people's needs had changed.
- Staff knowledge of people's support needs was inconsistent, and as records were not clear, people were exposed to the potential risk of harm and of receiving unsafe care.
- We raised our concerns with the provider who took urgent action to address these concerns. On 25 November 2021 we found the provider had now identified people's overarching care needs and associated risks. Where a mobility and personal evacuation plan had been updated this was of a good standard. However, we continued to find further areas which had not been reviewed or mitigated, such as how risks to people who smoked had been reviewed.
- The new manager was working with the provider's external consultant to put care plans and risk assessments in place. On 02 December 2021 we continued to find care plans and associated risks had not been fully identified or robustly reviewed. The provider confirmed time would be needed to ensure all people received a comprehensive review of their care and support needs.
- We shared our concerns with external agencies, such as the fire service, environmental health, the local authority commissioners and safeguarding.

Using medicines safely
- At the last inspection we identified a breach of regulation in relation to medicine and served the provider with a warning notice, to improve the standards of medicines management. At this inspection we continued to identify concerns with the management of medicines. This meant people were continuing to be exposed to potential harm.

● On 04 November 2021 we found examples were people's medications were not given as prescribed. For example, three staff gave different answers for who required thickened fluids. There were no medication administration records (MARS) available to show who was prescribed this medication. In addition to this, the pot of thickener staff were using had the prescription label torn off at the bottom, so it could not be identified who it was prescribed to. We raised a safeguarding with the local authority as we could not be assured people were receiving medications n a safe way.
● Medicines received into the home were not counted on receipt and daily running totals were not recorded. This placed people at risk of potentially being underdosed or overdosed, as the provider could not be assured people received their medication as prescribed as records were not accurate. On 25 November 2021 we continued to find no daily running totals entered on MAR charts.
● Where staff had received medication competency checks, and found to have shortfalls in their knowledge, we found staff continued to administer medicines, this was not in line with the providers policy. Following our findings, the provider told us staff medication competencies had been re-checked to ensure they were now safe to do so.

Preventing and controlling infection
● At the last inspection we identified concerns with how the provider prevented and controlled infection. At this inspection we continued to identify concerns with some areas of preventing and controlling infection.
● We were not assured that the provider was admitting people safely to the service. Due to lack of records held, the provider could not be assured people were admitted in line with government guidance to protect people from risk of harm.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were areas of the home that required maintenance to ensure the facilities were in good order and easy to keep clean. For example, furniture in unused bedrooms was found to be broken and stained, there was thick dust, dead insects, along with unknown people's toiletries, chocolates and clothing items. Inspectors raised concerns that people could enter these rooms. On 08 November 2021 during the provider meeting, the nominated individual advised they would not lock vacant bedrooms as some people, "Might like to go in there to eat their lunch or relax." The provider could not be assured the empty rooms were cleaned and maintained to a good standard to ensure people's safety was fully promoted and that risks to people had been mitigated.
● We were not assured that the provider was using PPE effectively and safely. We saw care staff did not consistently wear appropriate PPE, such as disposable aprons and gloves when providing personal care to people. In addition to this, these care staff would then work in the kitchen to prepare people's evening meal. The provider could not be assured that this way of working prevented cross-contamination.
● We were not assured that the provider was preventing visitors from catching and spreading infections. Staff were not consistently following government guidance in relation to lateral flow testing prior to visitor's entry to the home or vaccination checks for professional visitors. We experienced times where staff did not ask inspectors for this information, and other visiting professionals confirmed the same.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There was no clear system in place for the safest and most practical way to dispose of clinical waste. Staff either used the laundry room to gain access to the clinical waste bin that was situated in the courtyard or carried clinical waste through the home. The provider could not be assured this system reduced the risk of potential spread of infection.
● We were not assured that the provider's infection prevention and control policy was up to date.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was accessing testing for people using the service and staff.

Staffing and recruitment
At our last inspection the provider had failed to ensure sufficient staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider did not have sufficient staff to meet people's needs as they also were required to carry out other aspects of the running of the home, such as cooking and cleaning. The provider had also not considered the skill mix of staff to ensure they were able to respond and meet people's changing needs in a safe manner.
● People told us they had to wait for staff to support them, which compromised their safety and dignity. We saw times when people required the toilet and were not always supported in a timely way with this. In addition to this, we saw staff were not always deployed effectively. For example, during handover, one person requested assistance with the toilet, a staff member said the person would have to wait as handover was progressing.
● On 25 November, inspectors found five people were up and dressed and of these four were sleeping in the lounge at 6:15am, those we saw were unable to tell us this was their choice and care records did not reflect people's personal preferences. One staff member told us they started to get people up at 04:45 "To help the day staff". Daily notes did not reflect what inspectors had seen or what staff had said.
●Staff did not always hear the call bell ringing on the newer wing. The provider advised they would rectify this, and also discussed a new call alarm system for monitoring waiting times. However, there were times when inspectors found people did not have a call bell to hand, when in their room or in the courtyard. One person told us t when they went outside and needed staff to bring them back in, they would be shouting for half an hour to gain staff's attention.
● We saw staff were task focused and their interactions with people, while kind, were fleeting.

The provider failed to ensure they had sufficient numbers of staff on duty to meet people's individual needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment processes were not robust to give the provider assurances that staff were suitable for their roles. For example, not all staff files had interview notes in them, full employment histories, previous employment references and the latest information regarding staff visas and Disclosure and Barring Service (DBS) check numbers.
● Following the 04 November 2021 inspection we requested further evidence from the provider, however from this information we could not be assured this was sufficient, and shared our information of concern with the relevant authority.

The provider failed to ensure recruitment procedures were established and operated effectively to ensure

that staff who were employed were of fit and proper person's. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● On the first two days of our inspection we found the previous manager did not always recognise when abuse or neglect may be occurring and could not evidence they had taken sufficient action to mitigate known risk. We heard a person raise their concerns to the previous manager, but they had not taken action to reduce and report the risk to the external authorities. The person told us their concerns had been continuing with no action taken. Following our visit, action was taken to mitigate risk.

● As the inspection progressed we found where staff had concerns of poor practice these had not been recognised or escalated to the provider in a timely way. For example, we found that some people who had been living in the home for a few of months did not have any care records in place to guide staff how to support them in the right and safe way. This placed people at continuing risk of harm as staff did not have all the information to support them safely and in the right way.

The provider failed to ensure systems were embedded to protect people from risk of abuse and operated effectively to investigate and respond in a timely manner. This was 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.

● Over the course of the inspection the provider worked with the safeguarding team and police to reduce the potential risk of harm to people living in the home.

● The provider told us they had recognised their staff team required further support in recognising and raising concerns and had sought an external mentor to work alongside their staff team.

Learning lessons when things go wrong

● The process for reviewing incidents and accidents within the home were not embedded to ensure actions taken were routinely reviewed so that further potential incidents could be mitigated.

● Since our February 2020 inspection, the service has continually declined in its standards. The provider had not been able to demonstrate that lessons had been learnt to drive improvement.

Inadequate

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 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 people's care, support and outcomes.

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

- Care and support was not planned and delivered in line with current evidence-based guidance. Assessments of people's needs were either not in place or lacked details.
- Through poor planning and assessment people experienced poor quality care. The provider had not considered people's individual preferences, for example, whether they preferred a bath or a shower. One person told us that they did not think the home had the facilities to provide them with a bath or shower and had not had a bath or shower since their arrival in September 2021.
- It was recognised that following the 04 November 2021 inspection, work was required to appropriately assess each person. The new manager had put plans in place to speak with people and where appropriate their relatives to gain a fuller understanding of people's preferences, to understand how these would be met.

The provider failed to ensure people personal preferences were being met. This was a breach of regulation 09 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider could not be assured that new staff who had not worked previously in the care sector had a robust and meaningful induction into the service. On two separate occasions, with two new staff members, we found them to be included in the staffing numbers on their second day of employment. In one case, one staff member had only received a two hour induction the previous day, and was then found to be working without the full complement of care staff as determined by the provider.
- The providers staff did not have dedicated time to attend training. Where training had been facilitated by the local authority, the staff who attended were also working a shift. This meant that either people's needs were not always being met, and/or the training being provided was not fully attended by the staff.
- We saw examples where staff did not recognise poor care, for example, when assisting people with their physical needs including using equipment. We saw an example where one staff member was supporting a person with lifting equipment alone and did not request support from another staff member. The inspector intervened, to ensure two staff were effectively and safely supporting the person and raised this with the provider.

The provider failed to ensure they had suitably qualified, competent and experienced staff on duty to meet people's individual needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Records held about newer people who had moved into the home was lacking. We saw examples where in some people's files, there was no detail of the person's Next of Kin, their doctor or where applicable their social worker. The new manager was working with the provider to put these details in place.

● Where people had been living in the home for some time, it could not always be evidenced that contact was being made with external agencies when required. For example, decisions were being made about people's care without any thought to involving those close to the person.

● The provider and new manager were putting steps in place to rectify these areas of concern, so that a more joined up approach could take place.

The provider failed to ensure people personal preferences were being met. This was a breach of regulation 09 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●The premises did not fully support people to maintain their independence. Outdoor spaces were not fully accessible to people who lived at the home. For example, people who used a wheelchair required staff support due to a step down from courtyard bedroom and uneven patio surface.

● There were 14 bedrooms on the lower ground floor, we found the people who lived on this floor were unable to use the lift independently, as there was no call button. To access the dining room and lounge people were dependant on staff to send the lift down for them to gain access to the upper floor.

● On 04 November 2021 the inspection team saw the flat roof above a person's bedroom had a large plastic tarpaulin tied on with various items, such as paint tins and a wooden crate. The previous manager told us the roof leaked. The provider told us the roof was going to be fixed mid November 2021, however on 02 December 2021, we found the roof to be in the same condition.

● On 01 November 2021 the previous manager told us one upstairs bathroom was locked as it was being replaced. On 04 November 2021 we found the partially dismantled bathroom was unlocked with the door was open. People were living upstairs at the time, and this posed a risk to their safety.

● 04 November 2021 inspectors found the cupboard in the laundry room where the boiler was housed, showed large gaps in the ceiling posing a fire risk. The expansion tank was not fixed to the wall but held up by a bucket on the floor and electrical sockets were hanging from the walls. In another cupboard next to this, which housed the water tank, the fuse box did not have the cover in place, and it could not be ascertained if the mains supply was isolated. People had potential access to the laundry room as the door leading to the courtyard from the laundry room was unlocked and ajar.

● We urgently raised our concerns with the provider, who immediately took action to address the laundry room and partially dismantled bathroom. However, we found that risk had not been fully mitigated as people still had access to the laundry room through the courtyard door, as we found this continued to not be locked, and people had unsupervised access to the courtyard.

The provider failed to ensure the premises was suitable for the purpose it was being used. This was a breach of regulation 15 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 when this is in their best interests and legally authorised under the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had not been working in line with the principles of the MCA. On 01 and 04 November 2021 the previous manager was unable to confirm whether any person had a current DoLS in place.
● We spoke to one person who felt they were being unlawfully deprived of their liberty and requested our help to leave the home. We advised the provider and previous manager that urgent action was required to ensure the person was being supported in the right way. We raised a safeguarding to ensure action would be taken.
● The provider could not be assured all people, where appropriate, had been assessed to understand if a DoLS authorisation was required. We raised our concerns to safeguarding at the local authority, so they could work with the provider to put plans in place to rectify this. Since this time reviews have taken place, and authorisations have been put in place, where this was urgently required.
● Following the 04 November 2021 inspection, the provider reviewed all records held, and worked with the local authority DoLS team, which in turn identified that some people did have DoLS authorisations in place. The provider and previous manager had been unaware of these and their associated conditions within them. Therefore, the provider could not be assured they were complying with the conditions within the authorisation.

The provider failed to ensure people were not deprived of their liberty without lawful authority. This was a breach of regulation 13 (5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People who required support to eat their meals was not done so in a positive way. We saw staff were busy and did not have time to sit with people to assist them. Instead, staff would support them while passing to complete the next task. We raised this with the provider who recognised that improvement in mealtime experience was required. For example, we saw staff would not stay with the person while supporting them to eat their meal, as they were completing other tasks
● People's weights were taken, however records to demonstrate whether any action was required, such as if a person was experiencing unexplained weight loss was not available. The providers consultant was supporting the new manager to put processes in place to routinely monitor people's weight, so action could be taken if required.
● We saw people were supported with food and fluids, however the provider could not be assured people were supported with this in line with their current medical needs, as records held were not complete or comprehensive to ascertain this. For example, we saw records for one person which showed their doctor had requested them to be placed on food and fluid charts, however the records held did not demonstrate this had happened. Without clear records and systems in place, people were at risk of receiving inappropriate care and treatment.

● Most people told us they enjoyed the meals offered and we saw some people were offered alternative choices if they did not want what was on offer.

Inadequate

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 has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not maintained. People told us they had to wait for staff to support them to use the toilet and gave examples of where their dignity had been compromised, as staff were too busy supporting others.
- People were not supported to maintain their personal care preferences, such as regular baths and showers, care records did not provide peoples personal preferences. One person told us they had not had a bath or shower for three months and would very much like one. The new manager recognised this was an area for improvement.
- The environment of the home did not support people's privacy. We saw people's bedrooms and a communal bathroom did not have adequate window dressings to ensure people could maintain their privacy. One bedroom, which looked out onto the street, had broken blinds, while the bathroom had no window covering.
- People's possessions were not treated in a respectful way. On 01 and 04 and 25 November 2021 Inspectors found vacant rooms held previous residents of the service items, such as clothing, toiletries, personal items, Christmas cards and chocolates
- On 01 November 2021 the courtyard held many walking frames and walking sticks, some had name tags on of people who had passed away.
- Towels and face cloths in people's rooms were ripped and frayed, bed linen was also found to be worn, frayed and had holes in.

Ensuring people are well treated and supported; respecting equality and diversity; supporting people to express their views and be involved in making decisions about their care

- People told us, and we saw staff did not have time to meet people's preferences. Care staff were completing other roles such as cooking and cleaning, which took them away from their caring role. Staff did not always have time to sit and talk and have meaningful conversations with people as staff worked with a task focused approach to their work.
- Several people told us that night time was noisy with people shouting, calling and entering their rooms. Care plans and daily notes did not reflect people's anxiety at night. This meant management did not have a clear idea of people's experiences to enable them to seek the right support and treatment for people.
- The provider had begun to develop care plans to support people's preferences, however these had not been shared with the staff. The provider was working alongside the new manager to communicate these to staff.

The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us staff treated them with kindness and staff worked hard to support them. However, we found evidence of a culture where people were not respected or valued.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had not been involved in developing their care plan. We saw examples where people who had lived in the home for around three months did not have any, or very limited care plans in place. In one record we viewed, details such as next of kin, the person's doctor or important phone numbers were not held within the care records.
- Where people had lived in the home for a longer period of time, care records were out-dated and no longer relevant to the person's current care needs. Where attempts had been made to update the records, there was no written detail to provide staff with guidance on how to meet people's needs in line with best practice.
- On our return visit on 25 November and 02 December 2021, the provider had begun to make improvements to people's care records, and care plans, and details of contact information was being recorded. We continued to find shortfalls in peoples care records on these dates, the provider recognised it would take time to improve records that improving records would take time to improve.
- From the records held, and observations made, the provider could not be assured staff were maintaining people's interests and hobbies. We saw some arts and crafts activities on 04 November 2021 which people seemed to enjoy, however on other days, people were not engaged in any personalised social activities that were individual to them.

The provider failed to ensure people personal preferences were being met. This was a breach of regulation 09 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw the provider did facilitate visitors to see their loved ones.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had not taken any steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.

The provider failed to ensure people personal preferences were being met. This was a breach of regulation 09 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● We saw in people's care records discussions had only always been held with people, or where appropriate their relatives about their end of life care wishes.

● There was no person receiving end of life care during the inspection. We looked at the care records of people who had passed away to understand how people had been supported. However, from the records written it could not be demonstrated that people received input from external agencies when required.

● Following our 04 November 2021 visit the provider had started to take steps to ensure people's wishes and support for end of life care had been considered, to promote and support people in receiving a dignified and comfortable death.

The provider failed to ensure people personal preferences were being met. This was a breach of regulation 09 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Most people we spoke with felt there was no-one they could raise their complaints to. Where one person had complained, they felt they were not listened to.

● The previous manager was not aware of the complaint's procedure for people, relatives and staff to follow should they need to raise a complaint, and said there were no complaints records as no complaints had been received.

● Prior to this inspection, in August 2021 we had been made aware of a complaint of the standards of care. The provider did not have a record of this.

● Where the provider had received a complaint, the details of this were not fully recorded to demonstrate this was followed in line with their complaints policy.

The provider failed to ensure they had established systems for responding and acting on complaints. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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 requires improvement. 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

At our last inspection the provider had failed to ensure the systems in place to monitor and measure the service were fully effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- This is the third consecutive inspection where the effectiveness of the provider's systems to monitor the quality of service had failed to identify concerns.
- People continued to be exposed to poor care and support as the providers systems for identifying and managing organisational risks were ineffective at mitigating the risks and promoting people's safety. The previous nominated individual said, "We WhatsApp [the previous manager] all the time, and phone everyday". However, this approach had not identified the significant concerns we had identified on inspection.
- The provider did not have robust systems in place to ensure all staff were following their safeguarding policy and procedures to protect people from harm.
- The provider's quality audit systems were not comprehensive or effective, actions were not identified and implemented to mitigate the risks, promote people's safety and strive for high quality care.
- The provider had some systems in place for monitoring the quality of the service, however where these had been undertaken they had not been completed in a robust way.
- The leadership within the home lacked continuity, which had a negative impact on the quality and standard of the service. Since February 2020 there had been six managers. Two managers who had registered with the CQC and no longer worked at the home.
- People were exposed to potential harm as staff lacked clear direction and support and not all staff understood their roles and responsibilities. Staff were not given honest feedback about how they were performing, and where improvement is needed.

The provider failed to ensure the systems in place to monitor and measure the service were fully effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the first two visit dates a new nominated individual has been put in place to oversee the governance of the service. A consultancy has been sourced, to support the new manager and put governance systems in place to support better monitoring. The nominated individual had put in place other external agencies to support the new manager with the environmental aspects of the building, and in addition to this a person to help the manager support the staff group. The nominated individual recognised that it would take time to improve the standard of the service and said, "Rosedale needs some TLC, and I will make sure it gets that".

Continuous learning and improving care
● Areas of concern which we identified on our last inspection continued to not be rectified, such as medicines management, staff recruitment practices and files, staffing, environmental deficits and infection control practices. We had found since our last inspection these areas of concern had significantly deteriorated.
● Systems for identifying safety concerns were not effective in addressing concerns quickly enough. Inspectors identified significant concerns with aspects of the safety of the providers electrical and heating system, which might pose a risk to fire safety. We raised this with the provider so they could rectify this area promptly. However, these areas of concern had been identified in May 2021 by an external company, but measures to make this area safe had not been carried out when we saw this in November 2021. We also shared these concerns with the fire service and environmental health.
● The environment of the home continued to place people at potential risk of harm, from concerns with the prevention of fire, to environmental areas such as continued trip hazards from loose patio paving slabs, to flat roofs that had not been mended. The issue with loose paving slabs had been previously identified at our inspections on 27 February 2020 and July 2021 and had not been addressed.

The provider failed to ensure the systems in place to monitor and measure the service were fully effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recognised the seriousness of the concerns and had taken urgent action to ensure peoples safety. They had brought in external resources, such as a health consultancy, environmental company to oversee the home environment, and support from the fire service to assess and mitigate risk. These measures were brought in to support the provider, the people who lived there and staff group.

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; working in partnership with others
● Some people we spoke with told us the service was not well-led, and shared with us their frustration of not feeling listened to. One person said, "[Previous manager] doesn't do anything. [They] can't manage a home, [they] do not know what they are doing".
● Staff were not always open and honest about the leadership of the service. The provider told us staff had

not raised concerns to them. Following the inspection the provider told us they had hired a mentor, who would talk with staff, provide guidance and supervisions, with the view that this would help staff to talk more openly about their views of the service.

● There had been a high turn-over of staff, the remaining staff were only a small group of staff to complete the care and ancillary tasks. We saw staff rotas which meant some staff were working 60 hours a week, and in two cases, 60 hours per week, along with five sleep-in shifts.

● Staff did not have consistent, corroborated information available to them on how to provide the right care and support to people. Staff had received very little training, supervision and guidance in how to provide a good standard of care.

The provider failed to ensure there were systems in place to engage and involve those who used the service were fully effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been poor collaboration with external stakeholders, such as doctors and district nurses. There was little evidence to suggest that contact had been made with other supporting agencies, such as social workers, physiotherapists or occupational therapists. The new nominated individual had recognised this shortfall and was working with the new manager to improve communication and information with external services for the benefit of people living at the home.

● The new manager was working towards developing people's care plans alongside support from a consultancy service. The new manager recognised there was a significant amount of work to do to improve the standards within the home, such as improving standards of care and promoting people's safety. They said, "I'm hopeful and positive that we will get there".

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 did not have robust systems in place for ensuring incidents and accidents were monitored, reviewed and mitigated. Where incidents had occurred, the provider could not be assured the correct agencies had been notified. We found examples, where we had not been notified of events that had happened in the service. The provider told us this would be reviewed, and notifications would be submitted accordingly.

● The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each person living in the home, staff recruitment and training, and governance checks.

The provider failed to ensure the systems in place to monitor and review their governance systems were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was displaying their last CQC ratings in the hallway of the home.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have established systems in place to receive and act on complaints.

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 9 HSCA RA Regulations 2014 Person-centred care people personal preferences were being met

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Peoples dignity and privacy was not upheld

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Peoples care and associated risks were not reviewed or mitigated.

The enforcement action we took:

Imposed condition

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 Staff did not always recognise abuse. People were illegally deprived of their liberty.

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not maintained to a safe

standard.

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective, comprehensive or robust

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment of staff of not robust to ensure staff who were employed were fit and proper person's.

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Governance systems were not effective, comprehensive or robust

The enforcement action we took:

Imposed condition