Rosemary Limited

Rosemary Retirement Home

Inspection report

65 Vicarage Road
Wollaston
Stourbridge
West Midlands
DY8 4NP

Tel: 01384397298

Date of inspection visit:
21 January 2021

Date of publication:
14 May 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rosemary Retirement Home is a residential care home providing personal care for up to 23 people, including older people and people who may be living with dementia. At the time of our inspection 22 people were living at the service.

The accommodation had a communal lounge and bedrooms on the ground and first floor with some bedrooms having ensuite facilities.

People's experience of using this service and what we found
At our last inspection we found there were not enough staff to meet people's needs to ensure safe and quality care. At this inspection the staffing levels had improved but we had concerns about the skills and knowledge of staff and relevant training had not been provided.

The provider did not have effective systems to ensure people always received safe care and that medicines were managed safely. We found concerns regarding the storage and administration of medicines and the management of risks in relation to distressed behaviours, malnutrition and sore skin. There were inefficient systems to ensure monitoring records were accurate and completed in line with people's assessed needs.

People were not always treated with dignity and respect, staff did not always treat people with compassion and choices were not always respected. At our last inspection we had concerns that the governance systems were not effective to ensure the quality of the service. This continued to be a concern and the provider had not taken enough action to ensure improvement.

People were not supported to have maximum choice and control of their lives and staff did not always 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. Mental capacity assessments had not been completed for some key decisions when people lacked capacity.

There had been no adaption to the environment to support people living with dementia and we have made a recommendation that the provider refers to best practice guidance to make improvements. People told us the food was good and a they had a choice although further consideration was required to support people living with dementia to make a choice. Staff knew how to recognise and report concerns about people's safety and people told us they felt safe. People and relatives felt able to raise concerns with the management team and were generally positive about the care they received.

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 8 November 2019) and there were

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
We used our transitional monitoring approach to review information about the service. This focuses on looking at information about safety, how effectively a service is led and how easily people can access the service.

Following this we had concerns in relation to the assessment of risk and staff training and competency. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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

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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosemary 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 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 regulation 10 dignity and respect, regulation 12 safe care and treatment, regulation 17 governance of the service and regulation 18 staffing, at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rosemary 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
The inspection was carried out by two inspectors.

Service and service type
Rosemary 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. 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 inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority who commission care from the provider. 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 five people who used the service and three relatives about their experience of the care provided. We spoke with fourteen members of staff including the nominated individual, registered manager, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with a health care professional who visited the service. We reviewed a range of records. This included four people's care records and multiple 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 quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicines were not always stored safely. Prescribed thickeners were not stored securely in peoples' room, which had the potential to cause harm if people swallowed the powder. We raised this with the registered manager who took immediate action to address this.

● We had concerns about the storage of controlled drugs. Controlled drugs are medicines which required certain management and additional control measures. The cabinet which stored controlled drugs for pain relief was not secured to a wall as is required by safety standards.

● Staff were not always competent to ensure safe management of medicines. Staff had regularly recorded the fridge temperature as above the recommended temperature for safe storage of medicines. They had not raised this as a concern or taken any action to look into this further. This increased the risk to the safety of the medicines which could have been compromised.

● For some people who required medicines to be administered as and when required (PRN), there were no protocols in place for staff to follow. This included a medicine for pain relief. We found the person concerned regularly displayed distressed behaviours and would not be able to make a decision about when they needed this medicine. Staff's knowledge of when to give the medicine was inconsistent and they had not fully considered how the person may express they were feeling pain. This increased the risk of the person not receiving pain relief when needed.

● We reviewed the Medicine Administration Records (MAR) for people who were having prescribed topical creams applied to their body. There were no records of where the creams were being applied and gaps in the MAR records showed that some people were not receiving the treatment as prescribed. The registered manager took action following our feedback to improve the recording of creams.

We were not assured that all reasonable steps had been taken to ensure the safe management of medicines which placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Assessing risk, safety monitoring and management;

● Where people had demonstrated 'distressed behaviour', care plans and risk assessments were not always in place. Staff we spoke with were not always aware of potential 'triggers' for behaviour, and there was no evaluation of the behaviour to learn lessons and further support people.

● People were not always protected from the risks associated with malnutrition. Kitchen staff were not aware of who was at risk of weight loss and did not have any records. For one person no action had been taken to seek medical advice when weight loss had been identified and there was no evidence of snacks being provided as identified on their care plan. This placed the person at risk of further weight loss.

● Monitoring records to support people at risk of skin damage and were inconsistent. Records did not show people were receiving support in line with their care plans. This increased the risk of people receiving unsafe care.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care, which placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Learning lessons when things go wrong

● Accidents and incidents were recorded however, there was limited evidence of lessons learned. For example, in relation to falls or people being found on the floor. Immediate action was taken but no analysis of the information or lessons learned highlighted.

Staffing and recruitment

● We received mixed views about staffing. One person said, "They are extremely good, I don't have to wait." Another person told us, "If you have to go to the toilet you have to wait, quite a bit sometimes."

● We observed good staffing levels in the morning and at lunch time but in the afternoon one member of staff spent considerable time supporting a person who was displaying distressed behaviours which had an impact on staffing levels. The registered manager advised this person was being supported to move to a new home due to the additional support they required and we were advised they moved shortly after the inspection.

● At the last inspection there were concerns about the number of staff working at nights. At this inspection improvements had been made and an additional member of staff was on the night rota. Staff we spoke with told us this had made a difference and there were sufficient staff to support people.

● At our previous inspection we found there were not always enough staff to support people at mealtimes as staff were having to carry out the preparation of meals. Improvements had been made at this inspection and we saw people were supported with their meals without delay.

● The provider had a recruitment process which involved recruitment checks to ensure newly appointed staff were suitable to support people. We found improvements had been made since the last inspection to ensure there was a record of the interview process.

Preventing and controlling infection

● Some staff were not wearing PPE appropriately, for example we saw four staff wearing visors when supporting people instead of a surgical mask. This was not in line with current guidance for preventing the spread of COVID-19 and no risk assessments were in place to mitigate the risk. The registered manager told us this had been immediately addressed following our inspection.

● At the last inspection there were concerns about the cleanliness of the service. At this inspection we found improvements had been made and the environment appeared clean. However, there was no evidence of how often and what parts of the service were cleaned.

● We were not assured that the provider's infection control prevention and control policy was up to date. Contingency plans had not been considered as to how they would respond if they did have an outbreak of COVID-19.

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

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

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

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they felt safe. One person told us, "Yes I am safe, there are so many people about." A relative said, "They are very safe there, I've never had any concerns. What I really like is the continuity of staff who get to know the residents, that's what makes the residents lives better."
● Staff understood the signs of abuse and how to report concerns. One staff member said, "I would report to management and document it. I can also phone the safeguarding team."

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had failed to ensure there was sufficient staffing, so people could be supported on a timely basis and safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we saw improvements in staffing at this inspection the provider had failed to ensure staff had the right skills and competency and the provider was still in breach of regulation 18.

Staff support: induction, training, skills and experience

- The registered manager and care staff did not always have the required skills and knowledge to recognise where care delivery fell below required standards. There were concerns identified in a range of areas including mental capacity, medicines management, diet and nutrition and distressed behaviours. As a result, staff were not always providing safe and effective care in these areas.
- The provider gave us a training matrix which showed most training was completed in 2018 with only a small number of training after this date. Staff who had started work at the service after this date had not received any training in safeguarding, moving and handling, mental capacity, infection control or dignity awareness.
- Regular competency assessments were not taking place to ensure staff had the skills and knowledge to support people. The registered manager told us they had carried out observations of staff but not recorded them. Some staff told us they couldn't remember when their last observation had taken place.
- We observed one person displaying distressed behaviours. One of the ways the staff member responded to this was by restricting their movements to keep the person in their chair. Staff had not received any training in dementia awareness or challenging behaviour since 2018. The staff member did not have the skills or knowledge to know how to support the person safely.

The provider's failure to ensure that the registered manager and staff team had the required skills and competency was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

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

- We observed a lack of engagement from staff with people who needed support to eat their meals. Staff did not explain what food they were giving the person and were talking between themselves with minimal conversation with the person.
- At the last inspection there were concerns people didn't get a choice of food at lunch time. At this

inspection we found improvements had been made and people told us they were offered a choice. However, people were given the choice the day before the meal and there was no pictorial menu. This was not supportive of people living with dementia.
● People and relatives gave positive feedback about the food. One person told us, "The food is grand." A relative said, "The food's really nice [person] tells me and they've put on weight."

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.
● Mental capacity assessments were completed when there was an application for a DoLs. For other key decisions there were no decision specific MCA assessments or best interest decision in place for people who lacked capacity. For example, when someone was having their movements monitored through a sensor alarm.
● Some staff had not received training in the MCA and DoLs, and staff knowledge in this area was inconsistent. Staff we spoke with were not sure which people had DoLs applications and what this would mean in terms of the support they gave people. This increased the risk of people having their liberty restricted.

Staff working with other agencies to provide consistent, effective, timely care, supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare services. However, there were some occasions when specialist advice had not been sought, for example one person had been assessed as needing a texture modified diet. They had continued to receive one food which was not modified in line with their assessment but there had been a failure to discuss this with health care professionals to ensure this was safe for the person. The registered manager agreed to address this when we raised the concern.
● People had oral health care assessments in their care plans however people's daily records were not completed to evidence the support given and staff had not received training .
● People and relatives told us they had access to health care professionals when required. A relative said, "They have had the doctor in when they weren't well, and they ring me up and tell me the advanced nurse practitioner is going in."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Relatives told us assessments were completed prior to a person moving into the service for the first time, however we didn't always see evidence of this. One person had been at the service for a two weeks and there were no assessments or care plans in place. This lack of recording increased the risk of inconsistent care.

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

● Improvements were needed to ensure the environment was adapted for people living with dementia. There was a lack of signage to help people orientate to time and place and the use of colour contrast had not been considered to make objects easier to see. The television and music were both playing in the communal lounge which did not create a relaxing environment for people.

We recommended the provider consider best practice guidance in relation to adapting the environment further to meet the needs of people who are living with dementia.

● There were two quieter areas where some people enjoyed spending time away from the communal lounge. These people were supplied with a call bell so they could request help when they needed it.

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 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.

At our last inspection there were concerns the provider had not sustained improvement within the service to ensure people received safe and effective care. This constituted a breach of Regulation 17 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the last inspection there were concerns the provider did not have sufficient oversight to ensure the quality and safety of the service was maintained. The provider had failed to make improvements in this area and no effective system was in place. Although the provider visited the service on a regular basis no audits were carried out to identify concerns and assess the safety and quality of the care provided.
- The provider had failed to develop effective systems to assess staff competency in their roles and to provide adequate training and development as required. We were advised that training had been impacted by the COVID-19 pandemic, however there had been no other consideration of how staff could receive support to ensure they were competent. We saw concerns with the skills and competency of staff and this had not been identified by the provider.
- At the last inspection we identified risk assessments were not completed for all identified risks. Although the new registered manager had made progress in this area this continued to be a concern. When risk assessments were completed, they did not always contain enough guidance for staff to follow, for example when people had diabetes or required support with moving and handling. This meant people were at increased risk of receiving unsafe care.
- People's medicines were not always safely managed. We found failings in the provider's quality assurance systems around medicine management and they had not identified the concerns we found on inspection.
- There was no system in place to monitor accidents and incidents. There was no oversight or systems in place to analyse information and use lessons learnt to reduce the likelihood of re-occurrence. The registered manager told us they did not know how to do this, and they had not received support from the provider to develop a system.
- Systems had failed to ensure good practice and adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knowledge was inconsistent in this area, and some consent forms had been signed by a person without the legal authority to do so.

● The provider had not made sufficient improvements since our last inspection to drive forward the quality of the service. An action plan had been completed by the provider but had not been effective in making the changes needed to ensure people always received safe and good quality care.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

● The provider failed to ensure people's dignity was always upheld within the service. We observed a person was distressed and crying. The staff member responded in an unkind way telling them to stop crying. Another staff member was seen supporting someone to eat whilst standing up. They were talking to other staff whilst supporting them and rushing the person to eat their meal.

● We saw people's bowel charts were kept on the back of the ground floor bathroom door. The door was unlocked, and the bathroom was accessible to everyone. This meant personal information about people had not been kept securely.

● The shower room was filled with equipment and was unable to be used. One person told us they liked to have a shower but hadn't had one yet. This option was not available to them which meant their personal preferences about how they wished to receive their care was not respected.

The provider's failure to ensure people were treated respectfully and that their dignity was promoted was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

● People and relatives gave good feedback about the care they received. A relative said, "When [person] was really poorly they wouldn't eat. The staff really supported [person] with the food they liked, I can't fault the effort they have put in."

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 registered manager and provider were open and transparent during the inspection. The registered manage took action in response to a number of the concerns raised, for example by ensuring staff were wearing PPE in line with guidance and improving their medicine systems for cream administration and storage of medicines.

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

● There had been no recent survey to gather people or relatives' views about the service. However, relatives told us the service kept in regular contact with them about any changes in needs of the person and they were happy with this level of contact.

● There was no effective system in place to ensure that people were involved in reviews of care plans, which meant the service was not consistently promoting person centred care.

● Staff told us they attended team meetings and the management was approachable if they needed to raise concerns and would take action in response to them.

● People and relatives spoke well of the service and felt able to raise concerns. One person said, "Yes I am able to raise concerns, they are all such a helpful lot.".

Working in partnership with others

● The service worked in partnership with other professionals and agencies, such as district nurses and social workers to ensure that people received the care and support they needed. One health care professional told us the service did recognise when people needed support but there had been some occasions when there had been a delay in seeking the appropriate advice.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving safe care.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were ineffective to ensure people received safe and good quality care.

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the skills and knowledge to provide safe and good quality care.

The enforcement action we took:

Conditions were imposed on the provider's registration.