Lifeways Rose Care and Support Limited

Rosekeys

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

About the service
Rosekeys is a residential care home providing accommodation and personal care to people with learning disabilities and autism. The service can support up to 13 people. There were 9 people using the service at the time of the inspection.

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

Right Support:
People were not 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 provider failed to ensure people were not subject to the least restrictive practice. Physical restrictions did not always follow care planning guidance.

Staffing levels did not support people to receive their assessed support. Staff did not always have the right training and knowledge to support people effectively and achieve good outcomes.

Governance processes failed to identify risk and improve the quality of the service.

Right Care:
Care was not person-centred and did not promote people's dignity, privacy and human rights. The service environment did not facilitate good care or promote people's dignity and privacy. Positive person-centred outcomes were limited, and this was not a focus at the service.

People were not supported to follow professional advice, sometimes putting them at serious risk of harm.

Staff and the management team did not understand how to mitigate risks and protect people from the risk of abuse.

Care plans and risk assessments failed to consistently outline people's needs and the staff team did not always understand the level of care people required.
People and most relatives we spoke with felt the care provided was safe.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. People's rights were not always respected and people were not free from unwanted restrictions.

Ineffective governance systems and a lack of effective partnership working meant there were closed culture concerns at this service. The provider did not have effective oversight of the actions of the management of the service and were not aware of widespread risks.

The manager was not always available for relatives and some staff told us were not always confident in the manager's approach.
People's rooms were personalised and areas of the service had decorations people could interact with.

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

Rating at last inspection
The last rating for this service was good (published 29 November 2021).

Why we inspected
We received concerns in relation to incident reporting, safeguarding, governance and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

We inspected and found there was a concern with deprivation of liberty (DoLS), so we widened the scope of the inspection to include the key questions of effective.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rosekeys on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to people's health and safety, safeguarding, staffing, dignity and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect. We will work with the local authority to monitor progress.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rosekeys

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 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.

Service and service type
Rosekeys is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rosekeys is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The manager in place had submitted an application to register. We are currently assessing this application

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people using the service. We spoke with the area manager, the manager, the deputy manager and 7 staff members. We spoke with professionals who work with the service.

We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We completed observations of people being supported. We reviewed a range of records including staff recruitment files, care plans, medicine records and management audits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not protected from the risk of harm.
- Medical advice was not followed. For example, a person was recorded to be acutely unwell, and staff contacted health professionals for advice. It was recommended the person was taken to hospital for checks, however, the manager told staff to not take the person to hospital and instead monitor them. The person was later admitted to hospital following further deterioration. In a further example, staff did not support a person to access medical advice despite a monitoring form of their specific health condition indicating it was required. This left people at risk of serious harm.
- Risks to people were not adequately assessed and mitigated. For example, a person who required support with their mobility did not have adequate information in their care plan and risk assessment to inform staff how to support them. Four staff members gave inconsistent feedback on how they would support this person to mobilise, and methods described were not always safe. This left the person at risk of harm from unsafe moving and handling practices.
- A person who presented with a behavioural risk to staff and other people did not have an adequate risk assessment. The manager told us how this risk was being mitigated but this was not documented in their care plan or a risk assessment. This left other people and staff who did not know this person well at risk.
- Lessons were not always learned following incidents. For example, in an observed incident, staff attempted to physically support a person away from an inspector unsafely. This was raised to the management team, but there was no incident form completed and there were therefore no documented lessons learned.
- Environmental risks were not mitigated. Electric heaters were not always at a safe temperature and risked people sustaining burns. A boiler room with exposed pipework was left unlocked and left people at risk of burns. A wardrobe was not attached to a wall in a person's bedroom and presented a risk to toppling for people with known risks of physically interacting with their environment. A communal cupboard holding substances, one of which was labelled to not be consumed, could have caused mild illness if ingested by people who may not have understood risks associated with them. Flooring was not always level, and this put people at increased risk of falls.

Preventing and controlling infection

- People were not always protected from the risk of infection.
- People's specific infection risks were not always assessed or mitigated. For example, a person regularly took part in an activity which put them at risk of infection, however, the management team had not documented this risk or taken any action to mitigate this. This left the person's health, safety, and welfare at risk.
- The service had widespread damage and wear to walls, skirting and furniture. This made them more

difficult to clean and more likely to harbour bacteria, increasing the risk of the spread of infection.
● Areas of the service had visible dust and stains and had not been cleaned. A person's bedroom had a large build-up of dust on a heater next to their bed. The communal conservatory had a large amount of cup stains and dust on top of surfaces. A pressure cushion left on a seat in the dining area had extensive staining on it. This increased the risk of the spread of bacteria and infection.
● Infection control best practice was not always followed. Contaminated waste was not always disposed of appropriately and this increased the risk of the spread of infection. A person's unused incontinence wear was stored on the floor and exposed and this risked cross contamination.
● Food was not always prepared and stored safely. Staff did not always wear appropriate PPE when preparing food. Open food and drink items did not always include a date of opening, so it was not clear if they were still safely consumable.

Using medicines safely
● Medicines were not always given as prescribed. For example, a person was prescribed antibiotics by a health professional to be given when presenting with pain. However, these medicines were not given to the person despite being recorded to have been experiencing pain. Another person was prescribed an 'as needed' medicine, but records stated this medicine was not given in line with the relevant protocol in place.
● Medicines were not always stored and recorded in line with best practice. Temperatures were not always taken in areas where medicines were stored so it was unclear if storage conditions were in line with manufacturers guidelines.
● Information in people's medicine care plans was not always consistent or in place. Prescribed creams did not always have body maps in place to inform staff where and how it should be applied. A person who received a medicine covertly, as agreed by a health professional, had inconsistent information about how this medicine should be given. This left people at risk of not receiving medicines safely and as prescribed.

The provider had failed to assess and mitigate the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Once concerns were highlighted by inspectors, the provider acted to remove environmental risks including heaters and the unattached wardrobe. The provider also took action to mitigate some people's specific risks, this included an urgent professional referral for a person's mobility needs and an update to their moving and handling care plan. There was also no evidence anyone came to harm from these risks.
● People we spoke with told us they felt safe. A person told us, "I'm happy here and I feel safe." Most relatives felt people were safe at the service.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse.
● In an incident where a person was physically restrained, staff failed to follow the person's care plan, and this left them at risk of harm. The provider failed to report this incident of physical restraint to the local authority safeguarding team for further external investigation. The person was not immediately safeguarded by the provider following this incident and was at continued risk of abuse until this was raised by inspectors.
● A person disclosed they had been subject to psychological ill treatment. This involved a threat of removing social opportunities for the person depending on their behaviour. This was reported to the local safeguarding authority by an inspector for further investigation.
● Further incidents had also not been reported to the local safeguarding authority. For example, a person had sustained multiple head injuries following falls, some of these unwitnessed. The provider had failed to report these incidents to the local safeguarding authority for independent review in line with local

procedures. This left people at continued risk of injuries from falls.

People were not protected from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were not always safe.
● The provider used a planning tool to help inform staffing levels, but rotas showed the calculated staffing levels included team leaders. These members of staff were required to complete other tasks such as medicines and administrative tasks and at these times safe staffing levels were not being met.
● Staff were not deployed to ensure people's assessed needs were met. For example, 2 people who required 2:1 support in the daytime were observed to not receive this level of support consistently. Staffing allocation records showed 1 of these people was not always allocated 2 staff members. This person was allocated 2 staff members due to the risks they may pose to themselves or others around them and so this was not mitigated safely. This was a failure to ensure safe and appropriate support was in place.
● A relative told us they felt low staffing levels had stopped a person going on a social trip.

The provider failed to ensure sufficient numbers of staff were deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us staff changed frequently but this had not had a noticeable negative impact on people's care. A relative told us, "Staff are always changing which is a pity as [they] get involved and become close, but then the regulars have gone." Most relatives we spoke with felt staffing levels were appropriate.
● Staff were recruited safely. Staff had relevant Disclosure and Barring Service (DBS) checks in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The members of the management team based at the service did not understand the MCA and did not ensure its principles were followed.
- A person was being deprived of their liberty unlawfully. This person had mental capacity to consent to their care and treatment but was restricted by staff and the management team and not always allowed to make their own decisions. This was a failure to follow the principles of the MCA.
- Conditions on which DoLS authorisations were subject to, were not always followed. Conditions for a person which stated therapy and medicine reviews should be requested within a set timescale had not been met.

The provider failed to ensure people were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- The provider worked with external professionals, but advice was inconsistently followed and this put people at risk.

● People were supported to eat and drink but this was not always safe. Health professional guidance for a person who was at risk of choking had not been followed and this put them at risk of harm.
● People at risk of weight loss were not always supported effectively. For example, a person had been recorded as losing weight and a health professional had advised weekly weight checks should be taken. Records showed these checks had not been completed and this put the person at risk of further unmonitored weight loss.

The provider failed to mitigate the risks relating to the health, safety, and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Once concerns were raised regarding an unsafe meal provided for a person at risk of choking, the provider acted to investigate and stated eating and drinking competencies were being completed for staff.
● Professionals we spoke with raised concerns about information not being shared by the management team. Despite these concerns, there was evidence of staff seeking medical advice where it was required.

Staff support: induction, training, skills and experience
● Staff did not always have the skills and experience to meet people's needs.
● Staff were observed to use inappropriate moving and handling techniques which could have caused injury on 3 occasions. Staff had completed manual handling awareness training, but some staff we spoke with felt practical training was required as staff members were not competent.
● Staff had not always received sufficient training to meet people's needs. For example, a person, who was diagnosed with epilepsy, did not always have allocated workers who had up to date epilepsy training. This put the person at risk of not receiving appropriate support in the event of a seizure.

The provider failed to ensure staff had received appropriate support and training to fulfil their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not assessed consistently.
● Care plans did not always include specific information about people's care needs. People with specific health conditions did not always have information in their care plans to inform staff how they should be supported.
● Care plans also included conflicting and outdated information. For example, 2 people had conflicting information in their care plans about their diets and preferences compared to summary sheets held in the kitchen. It was therefore not clear which information was correct. A person who had sustained a serious injury did not have any further information in their care plan about how staff should support them with this.

The provider failed to keep an accurate and contemporaneous record of people's care and treatment and decisions taken in relation to their care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite these concerns, people had examples of detailed information in their care plans to inform staff how to support them. For example, a person had a missing person profile which could be given to emergency services in the event they did not return to the service. Positive behaviour support plans also included information around the emotions people may experience and how to support them at these times.

Adapting service, design, decoration to meet people's needs
● The service was not always adapted to meet people's needs and to ensure people were treated in a

dignified way. For example, a person's drawer shelves were missing meaning their clothes were visible and not stored appropriately. Another person's bedroom had a used duvet left on the floor and incontinence products left out in their bedroom by staff rather than stored away. This was not a dignified approach to their care.

● A person's bedroom curtains were not in place following damage to them, and this meant light could enter their room and impact on their sleep. A privacy screening was placed on part of the glass windows, but this did not cover the whole window and the bedroom could be seen from outside. This did not protect person's privacy or dignity.

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

● The service environment was not always adapted to meet people's needs. For example, easy-read signage, which could have supported people to move around the service, was not always in place.

● Once concerns were raised by inspectors, the management team ordered replacement magnets so the curtain could be reattached.

● People's rooms included decoration and personalisation. The dining area had painted murals which people could engage with but there also damage a wall in this area. Christmas decorations were in the lounge area which encouraged interaction and reminded people of the time of year. A relative told us, "I went in yesterday and the Christmas decorations were lovely - they make a lot of effort."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Continuous learning and improving care; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. The members of the management team based at the service did not have a strong understanding of risk and regulatory requirements.
- Environmental risks outlined under the safe key question were not identified by the management team. Care plan reviews were also ineffective as these failed to identify and rectify the lack of risk assessments or information staff required to provide safe care for 5 people. People were therefore at risk of not receiving personalised care and safe support.
- Quality assurance systems failed to identify and address concerns at the service. There was no evidence of an accident and incident analysis, to identify themes and mitigate risk, despite a high number of incidents at the service. A monthly infection control audits had not been completed in both October and November and concerns raised in previous audits had not been actioned. Medicines audits did not include relevant actions where concerns had been found to mitigate future risk and failed to identify the issues we found on inspection.
- Systems to seek professional advice were not effective. For example, the provider failed to ensure a person received an adequate professional assessment for their mobility. This had been raised by the local authority approximately 3 months prior to this inspection. This left the person at risk of unsafe moving and handling practices. A further person had not been supported to adequately review their medicines intake. The person was prescribed antipsychotic medicines and a staff member told inspectors this made them sleepy. However, this was not raised to a health professional during their medicines review.
- The provider failed to have systems to ensure the upkeep and cleanliness of the building. This had led to the deterioration of walls, floors and soft furnishings which had become an infection control risk. The service did not employ a housekeeper and instead care staff had housekeeping duties, but this was not effective.
- Systems in place did not always support positive outcomes for people. For example, a person was supported into the community on 2 occasions in a two-month period. The management team told us the transport in place needed repair, however no alternative means had been sought. This left the person at risk of social isolation.

The provider's systems and processes failed to assess, monitor, and improve the quality and safety of the service provided. This placed people at risk of harm. This was a breach of regulation 17 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following concerns being raised by inspectors, the provider put a system in place to visually identify risks around the service. The provider also told us they were reviewing some care plans and risk assessments where concerns had been highlighted.
● The provider told us an internal audit prior to the inspection had identified there were concerns with the management of incidents at the service and this was in the process of being performance managed.
● There was some evidence of people achieving positive outcomes. For example, a person was supported to complete a qualification so they may be able to pursue employment in the future.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● As outlined in the safe and effective key questions, the provider did not always work well with other agencies, and this left people at risk. Two professionals raised concerns about information not being shared to other agencies.
● Staff we spoke with did not always feel supported by the manager or comfortable raising concerns.
● Relatives told us they had limited contact with the manager and mostly spoke to other staff when contacting the service. A relative told us, "It feels as if [the manager] is avoiding me." Some relatives also felt they were not always included in care and medicine reviews. The provider told us that they contact families when reviews are due.
● A yearly feedback survey for relatives was sent out around the time of the inspection. A previous survey had limited responses.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had received appropriate support and training to fulfil their roles.