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Rock Cottage Care Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service

About the service: Rock Cottage is a 36-bedded residential care home that was providing personal and nursing care to 30 people aged 65 and over at the time of the inspection.

People's experience of using this service and what we found
The service had improved since our last inspection, but further improvements were still needed.

People received their medicines safely. However, we found that audit systems in place could not sufficiently identify the numbers of medicines people had in stock.

People's support needs were planned and assessed for however, care files were inconsistent with information relating to person centred care and management of risks to people required strengthening.

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

There were inconsistent recording systems to evidence if people had been repositioned in accordance with their care plan needs.

The service was clean and free of malodour. There were a number of personal protective equipment (PPE) stations positioned throughout the home and staff wore appropriate PPE. Where new admissions came into the home, they were isolated for 14 days with evidence on their room door of when the isolation started.

People told us they felt safe in the home.

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

Rating at last inspection
The rating at the last inspection was requires improvement (report was published on 09 April 2019) You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Rock Cottage care services on our website at www.cqc.org.uk.

Why we inspected
We received concerns in relation to people's nursing care and how the service was promoting people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We undertook this focussed inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-

led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 a breach of Regulation 17 (Good Governance) of the Health and Social Care act 2008 (Regulated activities) Regulations 2014. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.
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.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rock Cottage Care Services

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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.

Inspection team
This inspection was carried out by one inspector and one assistant inspector.

Service and service type
Rock cottage care services is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
We gave 24 hours' notice so we could clarify the services COVID19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding so we could respond accordingly.

What we did before the inspection
We gathered information from the local authority's quality assurance and safeguarding team. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
Due to the national pandemic we completed a focused inspection therefore reducing the time we spent at

the service. We spoke with three people who used the service. We spoke with the registered manager, a nurse and the cook. During our time at the home we observed staff interactions with people. We looked at records relating to wound care management, risk assessments, care plans and accidents and incidents. We requested further information after our visit, this included contact details for staff, relatives and professionals.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two staff members, three relatives and one professional.

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.

During our previous inspection on 05 February 2019 we found that the service was not consistently safe and some improvements were needed. At this inspection we found some aspects of the service were not always safe. There was a risk that people could be harmed.

Assessing risk, safety monitoring and management

- Some peoples care files identified they were at risk of pressure ulceration and advised they were to be repositioned three-hourly. We looked at three repositioning charts which recorded re-positioning had not taken place in line with risk assessments. For example, for one person it was documented they had been repositioned at 13:36pm and then next documented evidence of repositioning was the following day at 08:32am. A second person who was on three hourly repositioning was repositioned at 00:00am and then the next documented time was 08:30am. This left people at risk of being supported inconsistently and at risk of pressure wounds.
- During the night shift the service used two different recording documents for repositioning, so it was not clear if people had been repositioned. We found gaps in the repositioning charts that were used, and neither system could evidence if the repositioning had taken place. Staff told us, they knew who the people were that required repositioning, however repositioning charts hadn't always been updated to evidence this.
- Care plans contained inconsistent and contradictory information. One person's care plan stated they needed bedrails, bumpers and a stand aid. However, further on in the assessment it stated they were to be hoisted and did not require bedrails. Whilst people were at risk of receiving inconsistent support due to their care records, staff we spoke with were aware of people's updated needs and risks. One staff member told us, "[Person] requires hoisting, they were using a stand aid, but they have been hoisted for a bit now, we get told this information during handover."

The registered manager acknowledged the inconsistences and stated they would ensure this was updated immediately.

- Care plans and risk assessments were reviewed by the registered manager, but they were not always up to date with accurate or current information. Not all actions or incidents relating to people's care had been documented. For example, one person had nine falls incident reports completed during 2020. However, on their falls risk assessment it stated this person had two falls incidents. This inconsistent information could mean that appropriate risk measures were not put into place to safeguard the person's needs.
- People's care files highlighted information on how to support specific needs. For example, people had individual care plans around their communication needs and support needed with their oral health.
- People were protected from environmental risks within the home, which had been assessed, and measures taken to minimise those risks. For example, hot water temperature checks.
- The registered manager told us, an initial pre assessment was undertaken virtually with the person to look

at their individual needs. Following this, care plans were developed, and risk assessments put in place considering needs around mental capacity, medication and pressure care.

Systems and processes to safeguard people from the risk of abuse

● Effective systems were in place to safeguard people from harm and abuse. All recorded safeguarding concerns had been recorded and action taken.

● People and relatives both told us about the safety in the home. One person stated, "I feel safe here, I see the manager often, they had a chat with me this morning." A second person told us, "I have lived here a long time, I enjoy being here, the nurses are all good when I need a bit of help. I feel safe here."

● People were supported by staff members who had a good understanding of safeguarding. All staff had received training in safeguarding and knew the process of raising a concern.

Staffing and recruitment

● Required staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff.

● However, the registered manager could not always evidence they had taken a full employment history of some staff. There was a document for these checks in some staff files, but not all. We alerted the registered manager to this issue. Following the inspection, the registered manager sent over evidence to highlight how they would gain staff's employment history.

● We found that people were supported by a sufficient number of staff. The registered manager was also available to support care staff.

● The service did not use agency staff. People and their relatives agreed there were enough staff to meet their needs.

Using medicines safely

● People did not have their medicines managed safely.

● The registered manager could not provide documentation of an accurate running total of medication stock that remained in the home. We carried out a random stock check of three people's medicines and found that the amount of medicine in stock did not match that recorded by the provider. This meant we could not be assured there were appropriate systems in place to safely manage medicine stock levels.

● MAR charts were not always signed for by staff who administered medication. For example, care staff supported people to administer prescription creams and then informed a senior member of staff who updated the MAR charts. These records should only be signed by the person who administered the medication. Therefore, we could not be assured prescription creams had been applied appropriately.

● Staff were trained to administer medicines safely and their competency to do so was checked regularly.

● Staff supported people to take their medicines in a respectful way. Staff ensured that people's dignity was maintained when administering medication. People were asked if they were ready for their medicines and were given time to take them.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

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

● We were assured that the provider was using PPE effectively and safely.

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

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks could be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● All accidents and incidents were recorded, and staff told us they knew the process of reporting an incident.
● The registered manager told us they undertook a root cause analysis each month to look at common themes and occurrences. However, we found this did not specifically look at information relating to times of falls or personal circumstances. Analysis would look at what shift an accident or incident occurred but did not focus directly on the person themselves, or specific evidence around their fall.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to have effective governance systems and processes in place to prevent abuse of service users. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been enough improvement 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

- Quality assurance processes in place were not effective. Records showed the registered manager checked three or four care files randomly each month. However, they failed to highlight issues that were found during the inspection. For example, the audits did not identify errors in care plans associated with people's risks. The inconsistent documentation meant that information was not reflective of people's needs, and this had not been appropriately picked up by the registered person.
- Medication audits were not completed effectively. During the inspection we identified the medicine count for people who were prescribed medicine on an 'as needed' basis was incorrect. The system in place to monitor this was ineffective. Part of the audits to count 'as needed' medicines had not been completed for the past three months as we were told a new electronic system was coming into place. Following the inspection the registered manager reintroduced audit forms that they previously used to ensure they could monitor the stock of their medicines.
- The registered manager did not have any audit systems in place to have oversight that people had been repositioned as per guidance in their care files. There were two separate recording mechanisms used, an electronic system in the day and an electronic and paper-based system for the night. However, these two systems did not complement each other. For example, during the night, where it had not been documented on the electronic form that people had been repositioned, the paper-based document could not evidence this, as it was not always dated. We could not be assured that repositioning had taken place. We fed this back to the registered manager who told us they are is going to put an audit processes in place so that she can monitor that people's repositioning is taking place.
- The registered manager was aware of their responsibilities to report significant events to CQC and other agencies. Notifications had been received in a timely manner which meant CQC could check that appropriate action had been taken.
- The registered manager completed other monthly audits which included mattress checks, infection prevention and control, sensory alarm checks and water temperature checks.

Continuous learning and improving care
● Robust systems were not always in place to ensure the service was consistently monitored and quality assurance maintained.
● However, the registered manager continually assessed mealtimes, staff members hand hygiene and completed a tissue viability audit to make improvements where necessary.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a clearly defined management structure within the service.
● The registered manager and staff worked hard to ensure the culture within the home was person centred. However, we found that care plans were not specific to people's needs.
● Staff worked hard to treat everyone as an individual ensuring their needs were met in their chosen way.
● Staff told us they felt supported by the registered manager. One staff member told us, "[Registered Manager] is very approachable and prepared to listen. The atmosphere is just so nice and relaxed."
● People told us they received high quality of care from staff. One person told us, "The staff are great and nice."

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 stated that they understood their Duty of Candour and told us, "I always inform people's relatives when there has been an accident."
● We found that accident and incident forms had been completed evidencing the date the next of kin had been contacted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff received training in relation to Equality and Diversity Rights as part of their induction.
● The registered manager was in the process of gaining feedback from a number of areas. This included staff, people and families. During the inspection they had received some feedback forms.
● The registered manager told us that people had maintained contact with family members virtually and via the telephone through the pandemic. They stated family members could sit outside the window and they would give the person a telephone so they could communicate with their family member. One person told us, "I talk to my family on the phone, I have my own mobile phone. My Niece has been to wave at me through the window, it's not the same, I really miss my visitors."

Working in partnership with others
● The service worked well with external professionals. Advice was sought as and when required ensuring people's changing needs were met as soon as possible. For example, on the day of inspection we saw where one person's health had deteriorated that paramedics were immediately informed and attended the person.
● The registered manager told us the service had close working relationships with district nurses, occupational therapists and pharmacies. One professional told us, "They [registered manager and nurse] are excellent, they are spot on with communication, no issues at all."

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.