Yellow Rose Lodge Limited

Holyrood House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Holyrood House is a residential care home providing accommodation and personal care to 23 people at the time of the inspection. The service can support up to 29 older people, some of whom may be living with dementia related conditions.

People's experience of using this service and what we found
People's health, safety and welfare was put at risk because the provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. There was a lack of provider and management oversight of the service.

At the last inspection, we found governance and monitoring systems had failed to identify areas of concern. This meant systems had failed to ensure risks to people were mitigated. At this inspection, there had been a significant deterioration in the quality of care provided to people. Serious concerns were found which had not been identified by the provider's quality assurance system. Management and staff had not effectively recognised and managed risks and incidents, therefore, people were placed at risk of harm.

Some risks to people, and the need to update care records, had been identified by the manager and provider before our inspection visit. However, action to mitigate risks to people's safety had not all been identified and addressed. The provider was open with us about the failings in the service and was committed to making improvements.

People had been put at risk due to the poor oversight of the safety of the building. At the start of the inspection, there was a serious risk with the safety of windows on the first floor. The provider addressed some of the issues and window safety had improved by the second day of the inspection.

At the last inspection, we found some risk assessments contained contradictory information meaning people were not kept as safe as reasonably practicable. At this inspection, we found risks were not always assessed appropriately. Staff received relevant training, but this needed to be extended to include guidance to assess risks to people. There was not an effective system in place to learn lessons from incidents or accidents. This meant people continued to be put at risk.

Safe infection control systems and processes were not always in place. Parts of the home were not clean. Systems for the management of people's medicines had not always ensured they were managed correctly.

Although people told us they felt safe, the systems in place failed to ensure people would always be protected from the risk of harm and abuse. Incidents of potential abuse had been overlooked. These concerns were not escalated to relevant partner agencies as required, such as the local authority. The Care Quality Commission (CQC) had also not been notified. Staff understood their safeguarding responsibilities, but we could not be confident that every incident was investigated.

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 policies and systems in the service did not support this practice. People were not always given opportunities to make decisions about their care.

People did not always experience kind and compassionate care, as we found examples where people were exposed to the on-going risk of harm.

People did not receive responsive care, which met their needs. Care plans did not reflect people's current needs, and they were not an accurate or helpful tool for staff providing care. There was no evidence that people and their relatives had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis.

We saw good interactions from staff and people and their relatives spoke positively about the care and support they received. People's privacy and dignity was respected.

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 18 February 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when they would improve.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We found significant concerns during this inspection resulting in an overall rating of inadequate.

Enforcement
We have identified five breaches in relation to safe care and treatment including risk management, infection control, premises and equipment, safeguarding people from abuse, consent to care and treatment, and how the service is managed.

Please see the action we have told the provider to take 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. 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 of their 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Holyrood House

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 two inspectors, and an Expert by Experience on day one. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was completed by one inspector. The third day was completed by two inspectors.

Service and service type
Holyrood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service did have a manager registered with the CQC, but they were not present for any of this inspection.

Registered managers are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started working in the service three days before our inspection. We will refer to them as 'manager' throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and three visitors about their experience of the care provided. We spoke with ten members of staff including the provider, manager, senior care staff, care staff, activities and catering staff. We reviewed a range of records. This included two people's care records in detail and eight in part, and five medication records. We looked at five staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the manager and provider to validate evidence found. We looked at quality assurance records. We spoke with the local authority contracts and safeguarding teams.

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 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 appropriately assess, monitor and mitigate risks relating to the health, safety and welfare of people. 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

- People were not kept safe from avoidable harm.
- A first-floor window had a rotting window frame, and broken window restrictor. This meant we were able to open the window fully. Other windows were single paned glass. The window restrictors allowed some to open wider than the recommended health and safety guidance advises. Window restrictors had been checked and recorded as "All okay" in December 2019. This placed people at risk of harm.
- Assessments were not reviewed and completed appropriately when people were deemed at risk. One person's records stated they were at high risk of malnutrition; their records had no supporting information as to why they were high risk. In addition, the person's risk assessment for mobilising stated, "Ensure moving and handling assessment and instructions are reviewed monthly." There had been no moving and handling assessment completed.
- A person was assessed as high risk of falls when mobilising. One action to reduce the risk was "Ensure bed rails in place at all time" and to audit the bed rails every month. The bed rails had not been checked as safe to use since April 2019. Their risk assessment for injury/harm was recorded as low risk and stated, "[Name] is currently at no risk of harm." These inconsistencies and lack of appropriate guidance for staff could result in people receiving care and support which put them at risk.
- Staff who completed risk assessments had not been trained to do so. When we asked staff how they had assessed and reached the levels of risk for people, we were told they just followed on from the last risk assessments. This placed people at risk.

Learning lessons when things go wrong

- Accident and incident analysis was not effective.
- Accidents and incidents were recorded, however, there was limited evidence of investigations into possible causes, or preventative actions. One person had a fall; no investigation was completed. Records stated a preventative action as "Ensure staff are able to visibly see [Name] to show them the correct way and not become unsteady when no one is on hand to support." It was unclear how this has been identified as

the appropriate action to take. This guidance was not transferred into the person's care plan.

The failure to do all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Systems and processes were not in place to ensure the proper and safe management of medicines.
● There was a lack of information readily available to staff about high risk medicines. One person's medicine record stated, "Warning. Read the additional information given with this medicine." The medicine information sheet was not present in the records. A member of staff said they were unaware of the risks to the person from this medicine.
● Some people were prescribed pain relief patches. There were no instructions regarding where to apply these, or a body map record of where these had been applied each time. One person was prescribed a product to be applied topically to relieve pain; there were no records of application for ten days. This meant we could not be sure the person had received their medicines as prescribed.

The failure to demonstrate medicines were safely managed was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely, including controlled drugs.

Preventing and controlling infection
● Infection control risks were not identified and managed. Areas of the home, furniture and equipment had not been properly maintained or kept clean. This put people at risk of harm.
● In the sluice room, there were dirty commode pans, both staircase carpets were dirty and covered in debris. In addition, we saw carpets in some people's rooms were worn and dirty. Wheelchairs were covered in debris and stained, a shower room contained a dirty shower chair and commode, which had rusty wheels, and two people's bedrooms had unpleasant odours.
● Staff did not always follow best practice for the prevention and control of infections. A staff member wore a pair of plastic gloves during medicine administration. They handled boxes, keys and documentation throughout without changing gloves. We saw a dirty teaspoon hanging from a light pull cord in the medicine room. Staff told us this method of light pull cord had been in place for nearly a year.

The failure to ensure that the premises and equipment used to deliver care were properly maintained and kept clean for the purposes for which they are being used, was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have effective systems in place to protect people from the risk of abuse.
● Although people told us they felt safe, systems and processes did not operate effectively to prevent the risk of abuse of people.
● Safeguarding referrals were not consistently made to the local authority safeguarding team when allegations of abuse were made in the service. This prevented the safeguarding team from following up concerns and any action taken.

The failure to ensure systems and processes protected people from abuse and improper treatment 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.

The provider responded during the inspection and window safety and some infection control issues were addressed. We received confirmation via notifications and information from the manager that safeguarding concerns had been referred to the local authority. In addition, they confirmed all bed rails had been checked as safe to use.

Recruitment and staffing

- Recruitment processes were not robust.
- Staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. Records were not clear as to when the service had received these checks. This meant we could not be sure if the checks were completed before the person began working at the home. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting.
- One member of staff's file contained one reference from a person. It was unclear who this person was, and when they had provided the reference. The person was not recorded on the member of staff's application from as a referee.

We recommend the provider seeks advice from a reputable source about best practice in relation to the recruitment of staff to ensure people are protected from unsuitable staff.

- There were enough staff available to support people to meet their needs.
- People told us there were enough staff to support them. Staff said they worked well as a team and had sufficient numbers of staff day and night.

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.

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.

- Systems and processes to assess capacity were not thorough or robust.
- The provider did not ensure people's capacity to make decisions was properly assessed when needed.
- Staff had shared the personal details of one person without attempting to gain their permission to do so.

The failure to ensure service users' consent to care and treatment had been sought in accordance with legislation was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

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

At our last inspection, we recommended that the provider take advice and guidance in relation to people's fluid intake. The provider had not made improvements.

- People were supported with food and nutrition but records relating to this had not always been effectively completed.
- People's care plans outlined their nutritional needs and risks. However, these did not always contain consistent guidance for staff to follow. One person's risk of choking was assessed as low and their care need

for eating and drinking as high.
● Each person had their fluid intake recorded. Three people had a specific target of fluid to be reached each day. It was unclear how these targets had been assessed as appropriate for each person.
● People told us they got enough to eat and drink within the home.

Staff support: induction, training, skills and experience
● Staff had not always received training relevant to their roles. Staff who were responsible for writing risk assessments had not received any specific training in this area. Records showed that not all staff had completed an induction in preparation for their role.
● Staff were confident they had the skills and knowledge they needed to meet people's needs, but their supervision and appraisal had not consistently been completed in accordance with the provider's policy.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before admission to the home.
● Protected characteristics under the Equalities Act 2010, such as age, disability and religion were identified as part of people's initial assessment.
● The provider mostly ensured people received care which met their needs and took into consideration their wishes.
● We observed staff interacting with people and found they knew people very well and were able to respond to their general needs appropriately.

Adapting service, design, decoration to meet people's needs
● Overall, people's individual needs were met by the adaptation, design and decoration of the service. It was and spacious and some communal areas were available, which were used for activities and dining.
● Although the premises had been redecorated in part, we found areas that required attention. Some carpets were worn and one of the two bathrooms was not available to meet the needs of people who used the service. We spoke to the manager and provider about this and they said they would take immediate action to address these concerns.
● People were encouraged to furnish their bedrooms with personal possessions such as pictures and photographs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked in partnership with healthcare professionals.
● Visits to or from healthcare professionals such as GPs and nurses were recorded in people's care records.

Requires Improvement

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People did not always receive a service which was caring, as they were not always protected from potential risk, as documented in the 'safe' section of this report.
- There was a lack of opportunities through reviews, meetings and surveys for people and others to express their views and be involved in decisions about the care provided.
- Care plans lacked records or signatures to confirm people and their relatives were involved in making decisions and reviewing their care. People told us they were not aware of the information contained in their care plans.
- The provider had not collected the views of people since the last inspection.
- Staff were kind and caring when interacting with people. There were positive comments from people and their relatives about the staff team and words such as 'friendly, caring and cheerful' were used to describe them. One person said, "You can have a laugh with them, they are caring." A relative commented, "They are always friendly and easy to approach."
- Staff had completed training in equality and diversity. People's faith was documented in their care plans. At the time of the inspection, the manager told us no-one required help to follow their faith.

Respecting and promoting people's privacy, dignity and independence

- People told us staff treated them with dignity and respect. One person said, "Yes, they do. They always make sure I am comfortable." A visitor told us, "They seem to. I have seen nothing that would cause me concern."
- We observed staff engaged with people, smiled and used their preferred names. People responded well to staff and greeted them warmly.
- Staff understood the need to respect people's privacy and were observed knocking on people's doors before entry and then closing it behind them when delivering tasks such as personal care.
- People were supported to maintain and develop relationships with those close to them. We saw visitors were frequent and welcomed into the home.
- People told us that staff encouraged them to be as independent as possible by letting them do whatever they could. A visitor told us their relative's mobility had improved following support from staff.

Requires Improvement

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 requires improvement. At this inspection, this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Information relating to people's care needs was inconsistent.
- Care plans for some people contained information that was not consistent with their risk assessments. For example, one person's plan recorded they were at high risk of falls, and low risk of injury.
- Care plans were subject to regular 'tick box' reviews on the electronic recording system. However, these were not effective because the reviews did not record what, if anything, had been changed or if the person had been involved.
- Staff demonstrated they knew people's likes, dislikes and preferences well. However, some felt the care plans did not contain enough information about the person. Comments included, "There isn't enough information. There could be more detail in the plans." The manager told us, "We have identified issues such as poor care planning. The care plans are very limited."

End of life care and support

- End of life information was recorded in a standard section of a person's care plan. The plans were basic and did not show any consideration had been made to what people may want in relation to funeral arrangements, or in the event of sudden death. It was unclear how people had been involved in these discussions.

We recommend the provider consider best practice guidance in relation to improving the quality of information in care plans and in documenting people's end of life wishes.

Improving care quality in response to complaints or concerns

- The provider had a policy and system in place to record, investigate and to respond to any complaints raised with them. The policy did not include contact details or the role of the Local Government Ombudsman, or the local authority if the person was not satisfied with the provider's response. The manager told us they would address this with the provider.
- People told us they had never needed to make a complaint.
- Records showed there had been no complaints documented since the last inspection.

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 manager understood their responsibility to comply with the AIS and some information was available around the home in different formats to meet people's diverse needs, if required.

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 received the support they needed to maintain relationships and meet their social and cultural needs.

● We saw evidence of activities taking place and some people engaging with them.

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 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; Continuous learning and improving care; 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; Working in partnership with others

At our last inspection, we found the provider's governance and monitoring systems had failed to identify areas of concerns. Systems had failed to ensure risks to people were mitigated. 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.

● There were widespread and significant shortfalls across the service. There was a lack of scrutiny by the provider to ensure that their systems for assessing and monitoring the quality and safety of the service were implemented, and to ensure regulatory requirements were met.
● The service had a manager registered with the Care Quality Commission (CQC). However, during the inspection, we met another manager who had recently been employed. Whilst the provider had recruited a new manager to run the home, they had not provided them with the information and tools they needed to do this effectively. This meant the manager had not recognised the inconsistencies we identified in how risks to people were being managed.
● Risks to people's health, safety and wellbeing was not always identified and mitigated effectively through on-going monitoring of the service.
● Audits were ineffective. A monthly medication audit stated daily audits were done to ensure medicine records were fully completed. These checks were not consistently done. Three daily medicine audits recorded missing signatures on three people's medicine records. There was no evidence to show this had been followed up.
● Statutory notifications were not submitted to CQC as required by regulations. The provider did not always share or report information about allegations of abuse with local safeguarding teams where this was required.

Systems were either not in place or robust enough to demonstrate there was adequate oversight of the service. This placed people at risk of harm. This was a further breach of regulation 17 (Good Governance) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Staff told us they liked working for the service, which had good teamwork. They said the culture at the home was improving but had not been good previously. One said, "We were not getting supported by management or anyone." Another told us, "Having [Name of new manager], they have quite a lot of good ideas are trying to put them into action. We hope the home can pull back together. We had a meeting and we were able to air our views."

● People, relatives and staff told us they were engaged through informal discussions. However, resident and relatives' meetings were rarely held, and the views of people and others was not obtained using surveys. The new manager told us they would address this.

● Staff worked well with health and social care professionals and followed their advice and guidance.

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 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment had not been sought in accordance with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to the health and safety of service users was not assessed and mitigated. Medicine were not managed safely.

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 Safeguarding systems were not effectively followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment had not been kept clean.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided.

The serious and varied nature of the breaches of the five regulations we have identified demonstrate a failure of leadership and governance at the service.