Rose Cottage RCH Ltd

Rose Cottage

Inspection report

14 Kipping Lane
Thornton
Bradford
West Yorkshire
BD13 3EL

Tel: 01274833641

Date of inspection visit:
06 October 2022
11 October 2022

Date of publication:
29 November 2022

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Rose Cottage is a care home providing personal care to adults living with dementia, and people with physical disabilities. At the time of the inspection there were 15 people using the service. Rose Cottage can support a maximum of 16 people.

People's experience of using this service and what we found
People were not always safe. Medicines were not always managed safely.
Risks to people were not always managed and some care plans were not reflective of people's current needs. Infection prevention and control was not properly adhered to or managed with a lack of daytime cleaning.
Staff had been recruited safely but there was not always enough staff to keep people safe.

People's nutritional and hydration needs were not always met and were not being monitored effectively. Portion sizes of food were small, with no choice offered to people on what meals were available to them. Staff told us the home regularly ran out of essentials. 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. We found no evidence of best interest decisions or consents being gained for sensor mats which were in place for multiple people, despite this being a restrictive practice.

The service was not always well led. Governance systems to monitor quality and safety were not effective. Audits were completed and sometimes identified shortfalls found on inspection, but no action had been taken to rectify the issues.

The provider gained feedback from people and relatives and maintained effective communication.

People were generally positive about the staff that cared for them in the service. Relatives were positive about the care provided to their family member. Staff feedback varied about the quality of the service provided and staffing levels.

The service worked with other professionals to benefit the people in the service.

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 1 December 2021) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by information of two incidents following which two people using the

service died. These incidents are subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of pressure damage and risk of unreported falls. This inspection examined those risks.

We also undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.
We inspected and found there was a concern around nutrition and hydration and mental capacity assessments not being completed, so we widened the scope of the inspection to include the key questions of safe, effective and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 not changed from requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, medicines management, infection prevention and control, consent to care, nutrition and hydration and good governance at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rose Cottage

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 first day of 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. The second day of inspection was carried out by 1 inspector.

Service and service type
Rose Cottage 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. Rose Cottage 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 a registered manager in post.

Notice of inspection

This inspection was unannounced on both days. Inspection activity started on 6 October 2022 and ended on 17 October 2002. We visited the location on 6 October 2022 and 11 October 2022.

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 5 people who use the service and 8 relatives about the experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with 10 staff members including the nominated individual, the registered manager, deputy manager and care staff. We spoke with one health care professional. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 9 peoples care records, sampling specific areas of another 6 peoples care records and daily notes and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including audits and policies.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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
At our last inspection the provider did not have systems in place to ensure medicine management was safe. This was a breach of regulation 12(1) 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.

●Medicines were not always managed safely. Transdermal patches were not rotated in line with the manufacturer's instructions. We found evidence one person's daily patch had been applied 14 times in the same location over a period of a month. The instructions state the patch must not be applied in the same location twice in 14 days.
● There was a lack of detail in the records around how the home was safely administering and monitoring medication. Time specific medications did not have timings detailed for when they had been administered. This meant no audit could be done to check these medications were being given as per prescriber's instructions.
● Paracetamol prescribed for one person four times a day did not have timings of administration on MARs therefore the 4-6-hour time gap between doses was not monitored.
● Medicines audits were completed regularly but failed to identify some of the issues we found on inspection.

We found no evidence that people had been harmed however, systems were not in place to ensure medicine management was safe. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Comprehensive 'as and when required' protocols (PRNs) were in place for all people with these types of medications.
●Safe storage of medication was monitored by temperature checks
● Systems were in place to ensure medicines were ordered, received and disposed of appropriately.
● The service had adequate supplies of medication for people.

Assessing risk, safety monitoring and management
At our last inspection the provider did not have systems in place to ensure risks associated with people's care were not always assessed or managed. This was a breach of regulation 12(1) 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.

● Risks to people was not always managed safely. Care records for 1 person had been updated with a comprehensive risk assessment for 2 hourly tilt and turns due to risks around pressure damage. We reviewed care records and found this had not been implemented and saw no evidence of interventions at night, and minimal interventions during the day.
● We found discrepancies in care files which led to confusion around people's current needs and requirements. Care documents for 1 person referred to a sensor mat for a chair being required at all times, however on inspection we did not observe this to be in place. On discussing with the registered manager, we were advised they no longer needed this in place, however care notes and risk assessments had not been updated with this decision.
● Nutritional risk assessments and care plans were in place which detailed the support staff were to provide with food and drink. These also detailed how regularly people should be weighed. Where people had lost weight and were nutritionally at risk, we saw no evidence of weekly weights being completed.
● Continence care plans failed to provide details around specific continence equipment people needed. Staff did not have clear guidance on each person's individual assessments of need.

We found no evidence that people had been harmed. However, risks associated with people's care were not always assessed and managed which placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed some actions had and were being taken to address the risks.

● Routine safety and environmental checks were in place. However, we found one fire escape route was not kept clear.
●The service had undergone a period of refurbishment including painting and decorating, new flooring and new bedding for people in the home.

Preventing and controlling infection
At our last inspection the provider did not have systems in place to ensure risks associated with infection prevention and control were assessed and managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The home did not have full time domestic staff working through the day, only part time working some evenings. Therefore, no cleaning was observed during the day of this inspection. We did not observe high touch points being sanitised throughout the day. Cleaning schedules and documentation were not contemporaneous and there were only 8 days in September where cleaning had been documented as completed.
● We were not assured that the provider was preventing visitors from catching and spreading infections. This was due to the lack of cleaning that occurred during the day, and the lack of hand gel in and around the

service available for visitors.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. We found when the domestic staff member were not on shift, the care staff were unable to complete cleaning tasks during the day.

We found risks associated with infection prevention and control was not always assessed and managed which placed people at risk of harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to address the risks.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●The provider was supporting relatives and friends to visit people safely. We saw relatives and friends were welcomed and could spend time with their relative where they preferred. The appropriate safeguards were in place to protect people.

Staffing and recruitment
● There were not enough staff to keep people safe on an evening. We observed only 2 care staff members working the evening shift, which left people unsupervised in the home and placed them at risk.
● We observed the lack of evening staff resulted in people not being supported or encouraged with their evening meals, people were left for periods of time unsupervised despite having risk assessments in place detailing they were at risk when not monitored.

This demonstrated the service was in breach of Regulation 18 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has responded since the inspection and informed us they have taken action to address the shortfall and increased evening staffing levels.

● Feedback on staffing levels was mixed from care staff. Some staff told us, "the staffing levels are fine, we always manage." Other staff told us "There is not enough staff, you cannot get all the care tasks done."
● Staff were recruited safely, and appropriate checks were carried out to protect people from the employment of unsuitable staff.

Systems and processes to safeguard people from the risk of abuse
● Systems protected people from potential abuse and neglect. The provider reported safeguarding concerns to the local authority and investigations were carried out when people were harmed.
● Staff had received safeguarding training and knew how to recognise and protect people from the risk of abuse.
● The registered manager and staff understood their responsibilities to safeguard people from abuse.

● People told us they felt safe at the service.

Learning lessons when things go wrong

● A monthly analysis of accidents and incidents was done but not fully completed by the registered manager, which meant analysis of trends and patterns could not be established. The provider informed us they were taking ownership of the accident and incidents and would be implementing a robust audit process.

● Staff and relative meeting minutes showed the registered manager and provider were responsive to suggestions for improvement within the service.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- We saw there was a lack of documentation for people who were nutritionally at risk to record the amount of food and fluid they consumed, and minimal detail on the food actually being offered to people, despite this being a requirement detailed in their care plans and risk assessments.
- Where documentation had been kept, we observed inaccuracies in the amount of food and fluids documented on the daily notes. We observed 1 person had not eaten lunch on 1 of the days of inspection, however when we reviewed the daily notes, care staff had documented the person had eaten 'all' their lunch and pudding. This meant monitoring of intake was not achievable as the documentation kept was inaccurate.
- We observed small portions of food being given for all people, with no choice over amounts or of what food they wanted. We did not observe seconds being offered despite the small portions at lunch and particularly teatime.
- Where people had lost weight and needed fortification there were no records kept as to what and how fortification was happening. Fortification is the practice of deliberately increasing the content of one or more micronutrients (i.e., vitamins and minerals) in a food to improve the nutritional quality. This increases calorie intake and can aid weight gain
- People's weights were being checked however, no action was taken when people lost significant amounts of weight, or consistently lost weight. Audits completed by the registered manager stated weekly weights were to be completed for close monitoring however, we saw no evidence of this occurring.
- People who were losing weight consistently were not being referred to GPs or dieticians timely. We observed over a 3-month period, 4 people had been consistently losing weight, but no action had been taken to contact other professionals for guidance.
- Staff reported they were regularly asked via messages to bring in food and drink from the shop, such as bread, milk, tea bags. A staff member said, "Food is very poor, there is always a what's app asking staff to bring in bread, milk etc". Another staff member confirmed, "They are always running out of food; they just don't order enough".

The provider had failed to ensure people's nutritional and hydration needs were met. This was a breach of Regulation 14 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has responded since the inspection and informed us they are taking action to address the concerns.

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). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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 service was not working within the principles of the MCA.
● Mental capacity assessments and best interest decisions were not in place for some people despite having restrictions placed on them.

The provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We received feedback from one professional who detailed concerns around the service and its responsiveness in situations where people are seriously ill. It was also noted that the service had several occurrences where telemeds were not working but no action had been taken. For example one person had become very unwell and the service had not been able to use the telemeds system to get advice. This resulted in the district nurse team who came in for different reasons calling the emergency servics due to how poorly the person was.
● People's care records showed involvement with other agencies such as GPs and District nurse teams.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Peoples needs were assessed before they were admitted into the service.
● The assessment was used to develop care plans and risk assessments.

Staff support: induction, training, skills and experience
● Staff received one to one supervision regularly and group training sessions. The training sessions were task based in response to shortfalls identified in the service by external agencies. Documentation kept on supervisions and the training sessions was robust and detailed.
● Staff induction processes were in place and these were followed.
● Competency checks were in place for those administering medication.
● Most staff were up to date with training and new sessions were booked in advance of the expiry dates of previous training.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were comfortably furnished and personalised.

● Adaptations were in the process of being made to the environment to meet the needs of people living with dementia and promoted their independence. For example, bedroom doors were updated to include people's names on to help them identify their rooms.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found systems and processes were either not in place or robust enough to demonstrate good governance. This was a breach of Regulation 17(1) (2) 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.

● Governance systems were in place but not always effective. The registered managers audits for medication, health and safety, accident and incidents were effective at identifying some issues, but there was no action taken to rectify the issues.
● Care plan audits had not identified where weekly weights were required; these were not being completed.

● Audits completed on daily notes identified issues with recording of nutritional intake and a lack of skin integrity checks, however these issues remained on inspection so had not been rectified.
● Audits failed to identify repositioning of people at risk of developing pressure areas were not being documented regularly.

This demonstrates a continued breach of Regulation 17(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a registered manager in post.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People who lived at the service and most of the relatives spoke positively about their experience of living at Rose Cottage.
● Relatives told us "We like the home; the staff are lovely" and "[Relative] loves the home, the staff are committed"."
● Staff feedback was mixed, with some staff stating, "It's a great place to work, I like it", while other staff reported "The care needs to improve."

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 understood their legal requirements to inform CQC of certain incidents which have occurred within the home. These statutory notifications are to ensure CQC is aware of important events and plays a key role in our monitoring of the service.

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

● The provider has continued to seek feedback from people and relatives using surveys. Analysis of the feedback was completed and shared with people, relatives and staff. One relative told us, "the what's app group is great, they send pictures of our relatives and [provider] says to just mention anything we want to be improved and we have a conversation about it on there."

● People gave positive feedback with one person saying, "I don't have to worry about anything, they do it all for me".

●Staff meetings were held to discuss performance related issues and improvements the service needed to make. These were well documented and were an opportunity for staff to share good practice and their views.

● The provider engaged with people, relatives and staff regularly and had a what's app group for the relatives where they shared updates on the service, activities people had undertaken and communicated effectively on this platform.

Working in partnership with others

● The registered manager worked with the GPs, district nurses, clinical commissioning group (CCG) and safeguarding teams.

Continuous learning and improving care

● The provider had robust systems in place for audits, inclusive of action plans for the management team. However, despite the provider identifying shortfalls and setting actions to be completed to improve the quality of service, these concerns were not always actioned, rectified or monitored for consistent compliance by management.

● Throughout the inspection the provider and registered manager were responsive to feedback and demonstrated a commitment to improving the service.

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 Regulation 11: The provider failed to ensure consent was not being sought and BID was documented/completed for restrictions placed on people assessed to have capacity. Reg 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Reg 12 (1) the provider failed to ensure safe systems were in place for assessing risks to people, medications were not administered safely, and infection prevention and control measures were not in place due to lack of cleaning in the service. 12 (1) (2) (a) (b) (d) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Reg 14: The provider failed to ensure safe systems were in place to document and monitor the intake of food and fluids of people assessed as nutrtionally at risk. Reg 14 (1) (2) (a) (b) (3) (4) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Reg 17: The provider failed to ensure good governance sustems were in place with adeqaute oversight of the service in order to monitor and continually improve the quality of the service. Reg 17(1) (2) (a) (b) (c) (d) (f)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Reg 18: The provider to ensure the service had sufficient numbers of staff at all times within the service to meet the assessed needs of people. Reg 18 (1)