Rose Cottage Care Limited

Rose Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service well-led?	**Good**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 February 2017. A breach of legal requirements was found. This was in relation to information which we must be notified about. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

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

Rose Cottage Residential Home is registered to provide accommodation and nursing care for up to 38 people. At the time of our inspection there were 35 people living at the service. The service is a single storey premises located in the village of Broughton near the towns of St Ives and Huntingdon. Most of the rooms have en-suite bathrooms. Each room has a call bell system, a telephone and TV point, and access to the internet. The service is based in a rural location, has landscaped gardens and a naturally occurring pond.

There was not a registered manager in post. However, two new managers had been recruited and they were in the process of applying to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our focused inspection on 1 September 2017, we found that the provider had followed their action plan in relation to reporting incidents. They had told us the actions would be completed by June 2017. Legal requirements had been met.

Systems and procedures had been introduced and these had been consistently applied in ensuring CQC had been notified about important events such as any serious injury to a person if this had occurred. Staff had informed external agencies such as a GP service and the local safeguarding authority where necessary.

Management and quality assurance processes that had been implemented since our previous inspection had been effective in driving improvement in the staff culture and audit records. This had resulted in accurate and appropriate reporting of all incidents that by law we needed to be informed about.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

The service had improved to Good.

We found that action had been taken to improve the identification and reporting of incidents. Effective quality assurance and governance arrangements were in place to identify and implement improvements.

An open and honest staff culture enabled the manager to be able to report incidents to the appropriate safeguarding authorities.

The provider and manager had ensured that they had notified us about events that, by law, they are required to do so such as serious injuries.

Rose Cottage Residential Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Rose Cottage Residential Home on 1 September 2017. This inspection was completed to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 3 February 2017 inspection, had been made. We inspected the service against one of the five questions we ask about services: is the service well-led? This is because the service was not meeting a legal requirement in relation to this question at our last inspection.

This unannounced inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service including notifications. A notification is information about important events which the provider is required to tell us about by law. The information we looked at included the provider's action plan, which set out the action they would take to meet legal requirements.

We contacted the local safeguarding authority which is responsible for investigating any safeguarding concerns they are informed about. We also looked at the action plan the provider sent to us in March 2017 to ensure the necessary improvements had been made.

During the inspection we spoke with two people living in the service, two visiting relatives, the manager, one team leader, one shift leader, one care staff and a member of the housekeeping team. We also spoke with a representative of the provider.

We looked at five people's care records, quality assurance and audit records, staff meeting minutes and medicines administration records. We also looked at records in relation to the management of the service including quality assurance, incident and audit records.

Good

Is the service well-led?

Our findings

At our comprehensive inspection of Rose Cottage Residential Home on 3 February 2017 we found that we had not always been notified about events that, by law, we have to be informed about. This was a breach of Regulation 18 of the Care Quality Commission (CQC) Registration Regulations 2009.

During this focused inspection we found that improvements had been made and the provider had followed the action plan they had sent us to meet the shortfalls in relation to the requirement.

We saw that the provider had written a new policy so that all staff were made aware of when to send notifications and to whom. We saw that a list of incidents that have to be reported was displayed in the staff room. Staff confirmed that they were aware of the new policy and how to notify CQC and other required professionals about any incidents. We saw that notifications had now been submitted promptly to CQC. We also received notifications of those incidents which had not previously been reported to us before our inspection in February 2017. For example, authorisations for people who had been lawfully deprived of their liberty. This meant appropriate authorities had the information they required in a lawful and timely way.

At this inspection we found that the provider was prominently displaying their previous inspection rating. At the time of our inspection a registered manager was not in post. They had left on 24 July 2017. The provider told us that two new managers had been recruited and that they were both going to apply to the CQC to become registered managers. We saw that the managers were supported by team leaders, a new role of shift leaders, care staff, as well as catering, housekeeping and maintenance staff. One person said, "I trust [managers] implicitly. When I have reported my concerns to them; actions have been taken straight away such as how I am supported with my medicines."

The staff culture had improved because of the support management gave staff in reporting and recording of incidents such as in care plans and incident forms. A relative said, "I get informed about everything that happens to my [family member] and if they have been to hospital and the reason for this." Another relative told us, "It doesn't matter how small the matter may be, they [management] take swift action." The provider's representative and managers told us that they now had the necessary information they needed to report incidents to the CQC and when required, the local safeguarding authority.

Recording of incidents such as those associated with medicines administration errors were now detailed as well as those for people at an increased risk of falling. This had been due to effective governance, audit and quality assurance procedures that were now in place. We saw that these incident records had been consistently completed since our previous inspection. Information recorded included that for what had happened, who the incident had been reported to and what actions had been taken to help prevent further occurrences. For example, we saw that there had been, changes to the time people had their medicines, the staff who administered these medicines and as well as any equipment to keep people safe, such as safe use of bed rails.