Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Rosecroft Residential Home

Westfield Drive, Workington, CA14 5AZ

Tel: 01900604814

Date of Inspection: 11 September 2014

Date of Publication: November 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Management of medicines	✖ Enforcement action taken
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Stilecroft (MPS) Limited
Registered Manager	Mrs Elizabeth Bedford
Overview of the service	Rosecroft is a residential care home that provides care and accommodation for up to 51 people. The home is situated in the town of Workington. Rosecroft is a large detached property set in its own grounds gardens with seating areas for people to enjoy the gardens and ample parking space. The accommodation is over two levels with a lift accessing the second floor.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 September 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a pharmacist. We talked with other authorities.

What people told us and what we found

We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five questions we always ask;

- Is the service caring?
- Is the service responsive?
- Is the service safe?
- Is the service effective?
- Is the service well led?

This is a summary of what we found:

Is the service safe?

We found that the service was not safe because people were not protected against the risks associated with use and management of medicines because they were not administered and recorded correctly. We found that care plans for the management of medicines and associated medical conditions were either not followed or did not address the needs of the people who lived at Rosecroft Residential Home. This meant that staff did not always follow or have clear guidance available to them to make sure that people received appropriate care.

Is the service effective?

People were protected from the risks of inadequate nutrition and dehydration.

Is the service caring?

People were cared for by warm and friendly staff who were knowledgeable about the people they cared for.

Is the service responsive?

People were cared for effectively because the staff worked in conjunction with other providers to ensure people's needs were met.

Is the service well-led?

Staff had a good understanding of the ethos of the service and quality assurance processes were in place. People who used the service and staff had been consulted with about changes and they had been listened to. The manager provided leadership and was aware of areas that required improvement.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 16 December 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Rosecroft Residential Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with people who used the service and asked if they were satisfied with the care and support they received. One person said, "I wouldn't be without them, they saved my life!" Another told us, "I love it!"

We spoke with relatives who were visiting the home, they were positive about the care and support provided in the home but had concerns about the amount of staff who had left recently.

We observed staff working and communicating with people in a warm and friendly manner. Various activities were being undertaken in the home which people appeared to be enjoying. The environment required some refurbishment which we discussed with the home manager. On the day of our inspection we observed that a significant amount of work was being undertaken to improve the exterior of the home and refurbish some of the bedrooms.

When we previously inspected Rosecroft Residential Home we judged that although everybody who lived at the home had a care plan in place they contained limited information. This had an effect on the people who used the service.

During this inspection we looked at 10 people's written records of care. We noted that the home had undertaken various assessments to establish what people's needs were. The assessments included gathering information on people's likes and dislikes, assessments of mental health and a dependency rating tool. The assessments were then used to inform care plans which outlined how day to day care was to be provided. We saw that the home had diversified the care plans to ensure people's varying needs were met. For example one person had a preference how they dressed for bed. Their wishes were supported in a comprehensive care plan which included a risk assessment. Another person required

support making complex decisions. Staff had put a detailed plan in place that outlined the person's levels of capacity and listed who should be involved in any decisions made.

We spoke with staff and asked if they had read people's care plans. Staff confirmed that they had. Furthermore when we asked about specific people's care plans staff were able to demonstrate their knowledge about people's care and support.

We saw that although the home had improved on the way they planned care there were still some plans that lacked detail and were not completely linked to the information gathered within the assessment. For example one person was diagnosed with dementia yet their psychological risk assessment stated they had no problems. We also found that there was a lack of care plans relating to physical health needs. For example people who required medication for diabetes and seizures did not have care plans in place that reflected this important need. This meant that although the home had made some improvements care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We spoke with people who used the service and asked them what they thought of the food provided by the home. One person told us, "The food is excellent." Another commented, "The food's very nice, you do get a choice." A relative said, "The food is good!"

We were present during lunch at the home and saw that people were offered a variety of different food. Staff offered assistance to people who required support when eating. Equipment, such as plate guards, was available to people who required it.

We saw that extra drinks and snacks were provided outwith mealtimes, some of the snacks were high in calories whereas others were quite low. We discussed people's nutritional needs with one of the cooks. They told us that people's different needs were catered for. For example some people were underweight and required a high calorie diet. One person told us their relative, "Was a bag of bones when she came here." The person went on to praise the staff for supporting their relative to gain weight.

We asked the cook about specialist diets for people with specific nutritional needs such as diabetes. The cook was able to identify which people required specialist diets and what type of diet was needed. The provider may wish to note that there was no formal documentation about people's nutritional needs kept within the kitchen environment. This meant that people may have been at risk of receiving the wrong diet.

We looked at the records which showed that the majority of people who needed to gain weight were. Where there was an issue with people's weight loss, or weight gain, the home involved the dietician or other professionals.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We spoke with people who used the service and asked if their needs were met by other providers as well as staff at Rosecroft Residential Home. They all agreed that if they were unwell additional professional support would be provided. One person told us, "They get you a doctor if you're poorly." Another said, "Yes, they'd get you a doctor or a nurse."

We looked at the written records of care. We saw that the local district nursing team were involved with the care of people in the home as well as GP's and local mental health services. Each visit by other providers of care was documented in people's records. During the inspection we observed district nurses attending the home as well as the local mental health services. One provider told us, "Things are improving, they're open and happy for us to drop in."

When we looked at the records in depth we found that other providers shared concerns if they believed care to be below acceptable standards. For example a district nurse had highlighted issues about one persons catheter not being correctly looked after. We also found some care plans that had been written in conjunction with other providers. This meant that staff at Rosecroft Residential Home worked in conjunction with other providers.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our inspection of this service on 22 April 2014 we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage them safely.

Following our inspection the provider wrote to us and told us that they intended to improve the way medicines were managed by 17 June 2014. They told us that they planned to re-train staff in the safe handling of medicines and to assess them as competent in the task. The management of records for the administration of medicines was to be improved. They also planned to review the way warfarin, a blood thinning medicine, was managed to ensure people receive the correct dose.

We undertook this inspection to check the provider's progress towards meeting this outcome following concerns raised at the last inspection. As part of this inspection we looked at records, medicines and care plans relating to the use of medicines. We observed medicines being handled and talked to staff and people who used the service. We found that people who used the service did not receive their medicines in a safe way.

Appropriate arrangements were not in place in relation to the recording of medicines. We found that medicines administration records were poor. We saw 34 medicines records that were not signed for the administration of medicines to people on the morning of the inspection. Two further people were awaiting their medicines and staff told us that they would sign all the records once all people had received their medicines.. For example, one person's record was signed for the administration of seven tablets on one day but when we counted the tablets we found that they had not been given. Another person was prescribed morphine capsules which was a controlled drug. The medicines administration record and the controlled drugs register had not been completed following the administration. This was contrary to the procedures in place in the service. We also found that the controlled drugs register had not been updated following the disposal of three medicines in July

2014.

We found that the recording of creams was poor. We looked at records for creams for two people. The service had administration records for creams that included a body map to advise care workers of their appropriate use. However, we found that body maps and records did not include all prescribed creams. We also found that creams were not applied correctly and records did not document the reasons for this. For example, one person was prescribed a skin softening cream called Diprobase "apply to dry skin twice daily as directed" but records showed that it was applied on 16 out of a possible 61 occasions between 12 August 2014 and the inspection date. We also found a cream in one person's bedroom that was documented as being applied but the pharmacy label showed that it was prescribed for a different person. The care plan for the person stated that they were at risk of developing blisters but there was no management plan in place to prevent this through the use of prescribed creams and this could result in skin that is not properly moisturised or protected.

Medicines were not safely administered. We found two pots of tablets for two different people in the medicines trolley. These were not labelled and it was not possible to identify to whom they belonged. Staff told us that the tablets in one pot had been refused by the person and the tablets in the other pot were waiting to be administered. This is dangerous practice as incorrect treatment could be administered in error.

We checked the handling of the blood thinning medicine called warfarin. This needed to be closely monitored with blood tests to make sure the dose was correct. We found that the blood test was 8 days overdue. Staff sought guidance from the on-call GP service the night before the inspection but for seven days prior to this staff continued to give warfarin without obtaining advice from a doctor. It was not possible to tell if the dose administered during this time was correct. This was contrary to the services procedures for the safe management of warfarin.

We observed the preparation of morphine liquid for administration to two people. We saw that a witness checked the measured quantity but did not check the prescribed instructions or witness the administration. The witness countersigned the controlled drugs register. We asked the witness if they normally witnessed the actual administration of another controlled drug and they said they did not. This was contrary to the services procedure for the management of controlled drugs.

Medicines were not disposed of appropriately. We saw staff returning a number of refused tablets back to the blister packs from which they were dispensed. These were sealed back into the packs using a sticker that stated "refused dose". This was poor practice as the incorrect tablet may be placed back in the blister pack and could be re-administered at a later date.

We looked at care plans relating to medicines and associated medical conditions in detail for three people. We found that these were either not followed or were poor. There were no care plans in place for the management of diabetes or seizures in people who were on medicines to control them. There was no care plan in place for a person who was prescribed a 'when required' sedative. This meant that staff did not always follow or have clear guidance available to them to make sure that people received appropriate care.

Medicines were not kept safely. Medicines were stored in a treatment room but the windows were not secure. The storage temperatures were inappropriate and did not protect the quality of the medicines. Records showed the fridge was too cold for the

storage of medicines. The temperature was recorded 19 times between 25 July and the inspection date with temperatures ranging from -3°c to -6°c. The fridge contained insulin and storage instructions stated "Store between 2° and 8°c. Do not freeze". We were concerned that staff had not addressed the issue of storage promptly. The treatment room was also too warm for the storage of medicines on 14 out of 19 recorded occasions from 25 July 2014 to the inspection date. Medicines that were stored at inappropriate temperatures may not work properly and could result in harm.

We judged that Rosecroft Residential Home had failed to improve and have served them with a warning notice which will give clear instruction as to when the home must become compliant. Failure to do say may result in further action.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

We asked the manager how people were involved in the running of Rosecroft Residential Home. The manager explained that she regularly spoke with all the residents of the home and worked alongside the staff to deliver care. Satisfaction questionnaires were also sent to people who used the service and their relatives. The manager formulated action plans from the feedback she was given. She explained that people had asked for a wider range of activities to be available in the home. On the day of our inspection we observed a game of bingo which was well attended. The manager also told us that a knitting club had been established and a gardening club. The vegetables produced in the gardens were used in meals prepared at the home. This meant people who used the service were asked for their views about their care and treatment and they were acted on.

The manager ensured that checks and audits were carried out to monitor the quality of service delivered at Rosecroft Residential Home. These included ensuring equipment was serviced and fit for purpose, that fire alarms were working and waste was being disposed of properly. The manager also regularly checked the environment and ensured that issues with maintenance were logged and repaired. Following a comment from a relative we looked at wheelchairs in the home and noted that these required attention, we informed staff who dealt with this straight away.

The manager told us that the area manager visited the home twice a week and contacted her by phone on a daily basis. The area manager ensured that checks were being carried out within the home. The provider may wish to note that checks and audits had failed to identify some of the issues outlined in this report.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because inaccurate and appropriate records were not maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We noted that records were kept securely in the main office in the home and that they were easily accessible when required. There was a policy in place for the management of records which included guidance on the disposal of records.

We looked at people's written records of care and saw that they were not always updated. For example the home used the Malnutrition Universal Screening Tool (MUST) to assess whether people required nutritional support. However we found that the majority of MUST's had not been filled. We spoke with the manager who explained that an alternate system of monitoring people's weight and body mass index (BMI) was in use. This information was not kept in individual people's records.

We looked at care plans relating to medicines and associated medical conditions in detail for three people. We found that these were either not followed or were poor. There were no care plans in place for the management of diabetes or seizures in people who were on medicines to control them. There was no care plan in place for a person who was prescribed a 'when required' sedative. This meant that written records did not always provide clear guidance to make sure that people received appropriate care. We judged that these omissions meant people were not protected from the risks of unsafe or inappropriate care and treatment because inaccurate and appropriate records were not maintained.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because inaccurate and appropriate records were not maintained.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 28 November 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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