Inspection Report

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

Rosecroft Residential Care Home

66 Plaistow Lane, Bromley, BR1 3JE

Tel: 02084644788

Date of Inspection: 02 April 2013

Date of Publication: May 2013

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
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✖ Enforcement action taken
Supporting workers	✖ Enforcement action taken
Assessing and monitoring the quality of service provision	✖ Enforcement action taken
Records	✖ Enforcement action taken

Details about this location

Registered Provider	C N V Limited
Overview of the service	Rosecroft Residential Care Home is located in the London Borough of Bromley and is registered to provider care for up to 20 people.
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 2 April 2013, talked with people who use the service and talked with carers and / or family members. We talked with staff and talked with commissioners of services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

People we spoke with told us they felt "well looked after" by staff working in the home. One relative we spoke with described their loved one as being "more content" since they had moved in. They felt that staff were "considerate" and had the necessary skills to care for people living in the home.

Staff we spoke with had a good understanding of safeguarding of vulnerable adults but had not always been adequately supported in their roles through training and supervision, in line with the provider's own requirements. Medication was not always stored securely and was not always administered in the way that had been prescribed.

We also found that people's care had not always been adequately planned and assessments of peoples' needs were not always consistent. Records were not always fit for purpose or securely stored and could not always be promptly located when required. Whilst the provider had a system in place to monitor key areas relating to the health, safety and welfare of people living in the home, regular checks were not being made in line with the provider's own schedule.

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 14 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Rosecroft Residential Care 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.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate 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

People's needs were not always adequately assessed and some assessments were inconsistent. The manager told us that each person using the service was admitted following an assessment of their needs although these assessments were not all available for review on the day of our visit because they had been archived. Following admission people were then assessed again in order to develop their care plans.

The provider had completed needs assessments for people living in the home after they had been admitted which covered areas such as nutrition, skin integrity, moving and handling and continence. However we noted that some assessments had been completed inaccurately. For example, one person had been assessed as being incontinent of the bowel in their physical health assessment but this had not been factored into their pressure sore assessment. This meant their pressure sore risk score fell into a lower category, putting them at risk of having inadequate care planning in this area.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. We looked at the records for five people living in the home and found that one person had no care plan in place. A second person's care plan showed no evidence of having been reviewed in the last four months and did not reflect their more recently assessed needs, referring to them as being continent when the assessment indicated that they were incontinent. This meant the person was at risk of not having their needs adequately met because their care plan was inaccurate.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We saw that appropriate policies were in place relating to the safeguarding of vulnerable adults, whistle blowing and complaints handling. These helped ensure that the provider took a consistent approach to dealing with any concerns raised by people, their families or staff working in the home although the provider may wish to note that the safeguarding of vulnerable adults policy had not been reviewed since 2009.

Staff members we spoke with were able to describe what constituted abuse and the action they would take if they suspected any form of abuse had occurred. They also told us how they would escalate any concerns they had if necessary and were aware of how to report concerns to external agencies. We were told that all staff had received training regarding the safeguarding of vulnerable adults although the provider may wish to note that according to their training records refresher training was overdue for some staff.

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 always 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 moderate 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

During our inspection of the home on 25 April 2012 we found that medication was not always stored appropriately and that the temperature of the refrigerator used for the storage of medication had not been regularily checked. We requested that the provider took action to address these issues. They submitted an action plan stating how and when the action would be completed.

At our inspection on 02 April 2013 we found that regular checks had been made of the the refrigerator temperature during the previous month. However, we found that the maximum temperature recorded by staff on each day over a three week period exceeded the maximum safe temperature for the storage of the medicine stored in the refrigerator. This meant that medicines in the home were not always being kept safely. When this issue was raised with the manager during our inspection they arranged for the medication stored in the refrigerator be replaced on the day of our inspection.

Medicines were prescribed but not always given to people appropriately. We found evidence that a medication round had been missed during the week prior to our inspection and people had not received their medication as prescribed. This meant people were at risk of not having the symptoms of their conditions alleviated through the proper administration of their medication.

Supporting workers

✖ Enforcement action taken

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not always adequately supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate 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

During our visit to the home on 25 April 2012 we found that staff had not completed mandatory training in some areas including health and safety and fire safety. We also found no evidence to demonstrate that staff had received regular supervision. We requested that the provider took action to address these issues. They submitted an action plan stating how and when the action would be completed.

At our inspection on 02 April 2013 we found that staff had still not received appropriate professional development in line with the provider's own requirements. The provider's training matrix was not up to date and did not include all of the staff currently working at the home. This meant that the manager was unable to provide an accurate overview of the training completed by staff. We looked at the training files for half of the care staff working in the home and found out of date training certificates in a number of areas. For example, all five of the staff whose training files we checked were overdue refresher training in moving and handling and four of the five staff were overdue refresher training in food hygiene according to the provider's training schedule. We also saw that only one person had attended fire safety training in the last twelve months according to the records. Therefore we were unable to assess if staff had received training to ensure that they had the skills and knowledge to deliver appropriate care.

The manager told us that very few staff had received any supervision in the ten months prior to March 2013 and no staff had received supervision on a bi-monthly basis in line with the provider's supervision policy. We saw that most staff had received supervision in March 2013 and the manager told us that regular supervision sessions were now being arranged for all staff. As this regular supervision had yet to be established we were unable to assess the impact it had on supporting staff. This meant people were being cared for by staff who were not adequately supported in their roles.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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 not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a moderate 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

During our visit to the home on 25 April 2012 we found that the provider regularly assessed and monitored the quality of the facilities and service provided at the home. However we also found that some improvements identified during these assessments had not always been implemented. We requested that the provider took action to address these issues. They submitted an action plan stating how and when the action would be completed.

We saw that the provider had a schedule of audits planned for the home which were used to assess key areas including medication, infection control, health and safety, care planning and checks on the kitchen area. However we found that the provider was not following their audit schedule and that regular checks were not being made in line with the provider's policy. For example, medication audits should have been conducted on a monthly basis but only one had been conducted between November 2012 and the beginning of April 2013.

We saw no evidence that audits of the kitchen area had taken place since November 2012 despite the provider's schedule indicating these should be conducted on a monthly basis. We were provided with no evidence of care plan audits having been conducted in the time since our last inspection. This meant that the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

Records

✖ Enforcement action taken

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 always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not adequately maintained.

We have judged that this has a moderate 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

During our visit to the home on 25 April 2012 we found that the provider's care plan audits undertaken in January and February 2012 had identifed areas that needed addressing including the improvement of Medication Administration Records (MARs). We also found that some people's personal records were not securely stored within the home. We asked the provider to take action to address these issues. They provided us with an action plan that stated how and when the issues would be resolved.

At our inspection of the home on 02 April 2013 we found that records were not always kept securely and could not always be located promptly when needed. For example, we were told that records of people's weight prior to January 2013 could not be found because they had been filed in a manner that ensured they could be retreaved when required. This meant the provider was unable to accurately determine whether weight loss over time was a risk factor that needed consideration in people's care planning. In another example the manager told us that the staff files of four people working in the home had gone missing and that the provider had taken the decision to start the process of replacing the information they contained. As this information had not been replaced at the time of our inspection we were unable to confirm this had been done and the provider had the necessary information to confirm the individual's identity, qualifications and suitability for their role.

People's personal records were not always accurate and fit for purpose. The manager told us that care plans had been stored electronically until recently when the computer they were stored on had broken. We were unable to determine exactly how long the computer had been broken for as we were provided with conflicting information. The manager confirmed that it had been broken for more than a month. The care plans had not been retrieved and returned to the home in that time. This lack of up to date information meant that in some cases people's care plans in the home were inadequate or no longer reflected their needs.

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: The provider did not always take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by the planning and delivery of care and treatment in such a way as to ensure the welfare and safety of the service user. Regulation 9(1)(b)(ii).

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 03 May 2013 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 always protected against the risks associated with the unsafe use and management of medicines, because appropriate arrangements were not always in place for the recording of medicines. Regulation 13.
We have served a warning notice to be met by 03 May 2013 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 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The provider was not always ensuring that staff were receiving appropriate training, professional development, supervision and appraisal. Regulation 23(1)(a).

This section is primarily information for the provider

We have served a warning notice to be met by 03 May 2013 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 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment because the provider was not effectively undertaking checks on areas of risk relating to their health, safety and welfare. Regulation 10(1)(b).
We have served a warning notice to be met by 03 May 2013 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 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not always protected against the risks of unsafe or inappropriate care because accurate records relating to their care had not been maintained, were not kept securely and could not always be located promptly when required. Regulation 20(1)(a), (2)(a).

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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