Rosevilla Care Home Stafford Limited

Rosevilla Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Rosevilla Nursing Home is a residential care home which provided personal and nursing care to 35 people at the time of our inspection.

The service can support up to 49 older people, younger people and people living with dementia and physical disability in one adapted building. The service provides a 'Discharge to Assess' service which provides support to people who have been discharged from hospital to enable them to go back to their own homes.

People's experience of using this service and what we found
Risks to people's health and wellbeing had not always been identified and assessed to ensure they were managed safely. Staffing was not sufficient to ensure people were supported in a timely way. Shortfalls in staffing were covered by the use of agency staff. Systems for ensuring people received their medicine as prescribed needed improvement. People were not always protected against the risk of cross infection within the home.

Current government guidance in relation to keeping people safe during the COVID-19 pandemic was not always followed by staff. The provider's own policies were not always followed for infection control, vaccination as a condition of deployment and admissions into the home. People's care records did not always evidence the support they had received. The provider's oversight and governance had not been effective in identifying and rectifying areas of concern.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good overall, with well-led rated as requires improvement (published 8 February 2019).

Why we inspected
We received concerns in relation to the management of risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to 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.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of risk, infection prevention and control, staffing and 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Rosevilla Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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
This inspection was completed by one inspector and one inspection manager.

Service and service type
Rosevilla Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. However, we gave short notice from outside the home due to the risks associated with COVID-19. We needed to know of the COVID-19 status in the home and discuss the infection, prevention and control measures in place before we entered the home.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, the local authority, safeguarding teams and other professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with 12 members of staff including nursing and care staff, housekeeping staff, the administrator, registered manager and deputy manager.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at records in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested quality assurance records and policies to look at. Not all of the evidence we requested was received.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The registered persons had not ensured staff took the required action to mitigate risk to people's health.
- Daily records to support risk management were poorly completed. People who were at risk of pressure sores needed support with repositioning to help ease pressure on their skin. It was not always clear how often people needed to be repositioned and different staff gave us different answers. People's records did not evidence they were re-positioned as frequently as their care plans indicated.
- Risks to people's safety and wellbeing were not always identified and assessed. One person had been admitted to the home six weeks earlier. Despite having two falls during this time, no assessment of this risk for falls had been completed. The person did not have a care plan which included the risks associated with their care.
- Prior to our inspection we were made aware of a serious incident in relation to wound care and sepsis. The registered manager told us no learning had been put into place following this incident.
- At the time of our inspection, some people were at risk of pressure wounds and others had pressure wounds. No protocols or policies were in place for the management of wounds, identifying sepsis or for escalating concerns and only some of the nursing staff had received training. This placed people at risk of harm.
- There was little evidence of learning from events or actions taken to improve the safety of people living at the home. Despite one person having two falls within days only one had been reported in line with the provider's system. Staff had not completed any assessment of risk in relation to falling for the person, which put them at an increased risk of harm.

People were placed people at risk of harm because systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Legislation came into effect on 11 November 2021 which means providers need to see evidence that staff and visiting professionals who enter the home are fully vaccinated for COVID-19, or are exempt.
- We were not assured that the provider was preventing visitors from catching and spreading infections. The provider had not ensured staff understood and followed their COVID-19 Vaccination Policy and this new legislation. Inspectors were not asked for their COVID-19 vaccination status evidence when they entered the home.
- The registered manager confirmed the correct evidence had not been checked for all staff as proof of their

COVID-19 vaccination status.

This was a breach of regulation 12(3) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People lived in a safe environment and told us they felt safe living at the home. Risks associated with the premises and equipment were managed through a programme of safety checks and maintenance at the home.

Preventing and controlling infection

● People were not always protected against the risk of cross infection within the home. Staff used hand held computers which they had with them at all times. These posed a cross infection risk because staff did not clean them. Staff did not always practice good hand hygiene when they moved between people's rooms or completed different tasks such as disposing of laundry.

● We were somewhat assured the provider was using PPE effectively and safely. Staff did not always wear their masks in accordance with the current COVID-19 government guidance.

● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Although housekeeping staff completed enhanced cleaning throughout the home due to the COVID-19 pandemic, it was not clear whether staff continued this in their absence. Touch point cleaning records were in place for staff to complete when the housekeeping staff were not on duty. These were not consistently completed, therefore the provider could not evidence enhanced cleaning at all times.

● Staff did not clean moving and handling equipment after use to help minimise the risk of cross infection between people. Equipment which is used with different people must be cleaned in accordance with current COVID-19 government guidance.

● We were not assured the provider was admitting people safely to the service. The provider's admissions policy did not align with current government guidance for the COVID-19 pandemic and staff were not clear on the isolation requirements for new admissions.

● We were somewhat assured the provider's infection prevention and control policy was up to date. Despite a policy being in place not all staff followed this.

We found no evidence people had been harmed however, the infection, prevention and control measures did not always support good practice. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We were assured the provider was accessing testing for people using the service and staff.

● We were assured the provider was meeting shielding and social distancing rules.

Using medicines safely

● The provider had not ensured the safe and proper use of medicines for all people at all times. Staff had administered a medicine to one person regularly every morning. However, this medicine was prescribed only to be given when needed to help calm the person. No records had been completed to show why the person needed this medicine every morning or to monitor its effectiveness.

We found no evidence people had been harmed however, the administration of 'as required' medicine was not always effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we asked the provider what action they would take to ensure people were safe. They sent us their action plan which provided assurances and showed the improvements they had started to make.

● Medicines were stored securely and in line with manufacturers requirements. Administration records were accurate and up to date.

Staffing and recruitment
● People told us they felt there were not enough staff all of the time and they were sometimes kept waiting for support. Staff told us they could only "do their best" when it came to meeting people's needs, but they felt there were enough staff.
● The staff levels had an impact on the management of risk at the home. The current staffing levels did not allow staff to be effective in assessing and monitoring risk and people's needs. There was a high level of agency staff use which impacted on the continuity of care people received.
● We heard people shouting for help and saw staff walk past their rooms with no acknowledgement of their distress or pain. This was because staff were busy supporting other people. One person repeatedly asked to go to the toilet and became distressed because no one went to them. Despite inspectors informing staff, the person was kept waiting and later soiled themselves, causing more distress to them.
● Staff told us the home got busier in the afternoons due to visits, new admissions and some people who experienced 'sundowning'. Sundowning is a term used for changes in people's behaviour which occurs mostly in the late afternoon, around dusk. People with dementia can experience a growing sense of agitation or anxiety at this time. However, staffing was not increased to support these events.

The staffing levels at the home did not help to ensure people's safety at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we asked the provider what action they would take to ensure people were safe. They sent us their action plan which provided assurances and showed the improvements they had started to make. New staff had been recruited and were waiting to start work at the home, pending recruitment checks. A review of staffing requirements had also been completed.

Following our inspection the registered manager told us that when staff had said they could "only do their best", they had meant that "sometimes their best was not good enough for some (people)".

● The registered manager had ensured people were supported by staff who had received appropriate employment and character checks prior to starting work with them. This included agency staff.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse because they were, on occasion, left without staff support when they needed it.
● One person who had been living in the home for a number of weeks did not have a care plan in place to guide staff on how to support them in the right and safe way. This placed them at risk of unsafe care.
● The registered manager was aware of their safeguarding responsibilities. They reported and took advice about safeguarding concerns from the local authority. However, they were not aware of the above concerns so had not taken any action. After our inspection, the provider sent us their action plan which included actions to address these issues.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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; Continuous learning and improving care

- At our previous inspection we had identified a concern with the monitoring of medicine stock levels and this was now improved. However, at this inspection we found issues around the management of risk, staffing and infection prevention and control. We therefore could not improve the rating for this key question.
- People were exposed to potential harm because the provider had not ensured staff had a clear understanding of their responsibilities with regards to current government COVID-19 guidance. This included new admissions to the home, checking the COVID-19 vaccination status of professional visitors to the home, temperature checking of people and infection prevention and control practice.
- The provider's quality monitoring systems had not identified the issues we highlighted during our inspection. There was poor monitoring of people's care plans, daily records and risk assessments to ensure these were complete and contemporaneous. Daily records were not completed in a timely manner despite staff having handheld computers with them at all times specifically for this reason. The provider could therefore not fully evidence what care had been provided to people.
- Staff did not have consistent or up to date information available to them on how to provide the right care and support to people. The provider had not ensured there were accurate records provided for the care and treatment of people living in the home. For example, one person did not have a care plan despite having lived there for several weeks and experienced falls during that time.
- Some people's care plans gave contradictory information on how often they should be repositioned. Staff also gave us contradictory information and most told us everyone was repositioned four hourly unless they were told otherwise. However, repositioning of people must be individual to them and is dependent on a number of factors including their health and skin condition and their mobility.
- The provider's risk management systems did not ensure incidents were monitored, reviewed and further potential risk mitigated. Lessons had not been learnt following a serious incident in relation to wound care and the provider's system for reporting incidents was not always followed.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. Following our inspection we requested supporting evidence from the registered persons for audit outcomes, meetings, outcomes of surveys and evidence of provider oversight, but these were not received.

We found no evidence people had been harmed however, the provider had not ensured risk was mitigated

by the systems they had in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we asked the provider what action they would take to ensure people were safe. They sent us their action plan which provided assurances and showed the improvements they had started to make.

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 was aware of their responsibilities under the duty of candour regulation. However, they had failed to identify and action areas of the service which required improvement.

● The registered manager understood their responsibilities in relation to their registration with us (CQC). We saw that the rating of the last inspection was on display and notifications were received as required by law, of incidents which occurred at the service. These notifications ensure that we are aware of important events and play a key role in our ongoing monitoring of services.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff did not show full respect for people and spoke about them as feeders, feeds, wanderers and their room numbers. We shared our findings with the registered manager. Following our inspection they told us they had begun discussions with staff about the use of the respectful language when talking about people who use the service.

● People who had rooms upstairs and at the back of the building told us they had little meaningful interaction with staff throughout the day. People who had their bedrooms on the main corridor in the home told us the environment was too noisy for them to get much sleep. Following our inspection, the registered manager told us, "No residents have said they feel they have little meaningful interaction with staff. One to one activity is every day, up to twice a day. (There has been) nothing reported or documented re concerns of residents not sleeping."

● Visiting to the home followed government guidance and essential care givers had been identified so they could safely support their family members in the home.

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

● The provider had mechanisms in place to gather feedback from people, their relatives and members of staff. People also had one to one time with the home's activity co-ordinator which gave them the opportunity to speak about their experience of care at the home.

● Most people we spoke with told us they felt settled at the home and although they felt more staff were needed, they considered staff worked hard for them.

Working in partnership with others

● The provider worked with multi disciplinary teams and external health professionals to support them in the delivery of personal and nursing care to people.

● Prior to our inspection we asked external agencies for feedback and although there had been concerns several months ago there were no recent concerns raised with us.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured risk was mitigated by the governance systems they had in place. Regulation 17(1) (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good Governance.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk of cross infection. The provider had not ensured the risks associated with people's care were assessed, monitored and recorded. This included the risks associated with sepsis. The provider had not ensured the proper use of medicines at all times. Risk associated with COVID-19 was not fully mitigated and current government guidance was not always followed. Regulation 12(1) (2)(a)(b)(g)(h) (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

The enforcement action we took:

We issued a warning notice which requires the provider to be compliant by 14 January 2021. We will return to the service after this date to complete another inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported at all times by sufficient numbers of staff. Staffing levels were not reviewed or adapted to respond to the changing needs of people or to new admissions to the home. Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

The enforcement action we took:

We issued a warning notice which requires the provider to be compliant by 14 January 2021. We will return to the service after this date to complete another inspection.