SNSB Limited

Roop Cottage Nursing and Residential Home

Inspection report

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Date of inspection visit:
27 January 2022
03 February 2022

Date of publication:
28 March 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Roop Cottage is a care home providing residential and nursing care to up to 35 people in one adapted building, across two floors. On day one of our inspection there were 22 people living in the home and on day two of the inspection there were 19 people living in the home.

People's experience of using this service and what we found
Risks to people's safety were not always assessed, monitored or managed effectively. Parts of the home which may cause harm to people were left unsecured and fire safety procedures were not adequate. Infection control measures were in place; however, they were not always effective. Staff were seen not wearing Personal Protective Equipment (PPE) appropriately and did not always follow government guidance. The systems in place to ensure people received their medicines as prescribed were not effective. Accidents and incidents were not consistently recorded or analysed, which meant staff could not learn from these events.

Staff were not provided with relevant training to ensure they had the right skills and knowledge to support people safely. Where there were systems and processes in place to monitor and improve the quality of the service provided, these were ineffective as they had not identified issues found at this inspection. The provider did not have a clear understanding of their regulatory responsibilities and failed to take enough action in response to the previous inspection, which led to ongoing breaches.

People and their relatives spoke highly of the care and support they received and gave positive feedback about the approachability of the home manager. Staff also told us they felt supported by the home manager.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 18 November 2021) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and we found the provider remained in breach of regulations.

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control. A decision was made for us to inspect and examine those risks.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We inspected and found there was a concern with infection prevention and control measures, as well as the deployment of staff and the management of the service, so we widened the scope of the inspection to become a focused inspection, which included the key questions of safe and well-led.

During this inspection, we also checked whether the provider had followed their action plan to confirm whether they now met legal requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roop Cottage Nursing and Residential 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 monitor the service and will take further action if needed.

We have identified breaches in relation to the management of infection control, medicine management, risks to people and oversight of the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Roop Cottage Nursing and Residential 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 carried out over two days by three inspectors.

Service and service type
Roop Cottage Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Roop Cottage is a care home with nursing care. 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. However, they were absent at the time of our inspection. 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.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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 the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with two people who lived in the home and three relatives about their experience of the care provided. We also spoke with eight members of staff including, the area manager, the home manager, nurse, senior carer and care assistants. We also spoke with a visiting professional.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and followed up concerns around infection control procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to take sufficient action to reduce risks to relating to the health safety and welfare of people. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Risks to people's safety were not always assessed or managed.
• People's care records now contained risk assessments, but staff did not always follow guidance contained within them. For example, one person was assessed as being at risk of choking and required support with food and fluids. We observed the person eating and drinking without support from staff on two separate occasions.
• The physical environment posed a risk to people's health and safety, as areas which may cause harm to people were not secured. We observed pots of water boiling on the stove whilst the kitchen area was unsupervised, and the door was propped open. Following the last inspection, where this was identified as a concern, a keypad had been fitted to the kitchen door to secure the area, but staff failed to ensure this was used.
• Personal Emergency Evacuation Plans (PEEPs) for people were not readily accessible in one central location for staff to access in the event of an emergency. One person's PEEP did not contain any specific information to support staff on how to evacuate this person safely from the building. This placed people at increased risk of harm in the event of a fire.

We found no evidence people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was 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 shared our findings with the local authority and asked the provider to tell us what they would immediately do to address the risks.

Using medicines safely

At our last inspection the provider had failed to implement effective systems for the safe management of

medicines. This meant people did not consistently receive their medicines as prescribed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Medicines were not managed safely, which placed people at risk of harm.
• It was not clear whether people received their medicines as prescribed. For example, one person's medicines record had not always been completed to confirm whether their topical medicines were applied.
• Staff did not respond promptly when people refused their medicines. For example, one person had refused their medication for nine days. However, there was no evidence staff had sought medical advice or support for this person.
• We observed some staff did not record the support they gave people with their medicines, at the time the support was given. There was therefore a risk that the records made by staff were not accurate.
• We were not assured of staff's competence to administer medicines. The home manager was unable to provide evidence staff responsible for the administration of medicines had their competence assessed. Competency assessments of care staff were either incomplete or overtyped and there were no competency assessments for nursing staff.

We found no evidence people had been harmed. However, people had been placed at the risk of harm from unsafe administration and management of medicines. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to implement effective systems to ensure government guidance around managing the ongoing pandemic was followed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Risks associated with infection prevention and control were not effectively managed.
• Staff were not using Personal Protective Equipment (PPE) safely. We observed several staff members in communal areas with masks worn below their nose or not worn at all. This was identified as an area of concern at the time of the last inspection. However, this had not been effectively addressed by the provider.
• Systems for the disposal of PPE were not adequate to prevent the spread of infection. We observed yellow bags were tied to handrails next to the sink in people's bedrooms, filled with used PPE.
• We were not assured that staff understood the requirements for self-isolation and testing. Staff did not always follow government guidance, which placed people at increased risk of contracting COVID-19.

We found no evidence people had been harmed. However, government guidance around managing the ongoing pandemic was still not being followed. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

• The service was following government guidance in relation to visiting and had a suitable system in place to support people to maintain important relationships with their relatives and friends.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.
• We found the service did not have effective measures in place to make sure this requirement was being met.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Systems and processes to ensure people were protected from the risk of abuse were not operated effectively.
• We were not assured the provider and staff understood their safeguarding responsibilities. Although, people told us they felt safe living at the home.
• The service did not always report safeguarding incidents to the relevant authorities and there was no process in place to learn lessons or improve practice.
• Staff had failed to report unexplained bruising they had identified to one person. This meant the incident was not investigated. As a result, the provider was not able to ensure appropriate action was taken or learn lessons from this incident.

Staffing and recruitment
• Staff were recruited safely. Procedures were in place to support safe recruitment and induction to the service.
• Systems and processes were not robust enough to ensure there were enough staff who were suitably skilled to care for people safely. For example, the provider was unable to provide evidence all staff had completed training in relation to safeguarding or fire safety.
• We observed care provided was task based and staff did not have time to spend in conversation or in meaningful activity with people.
• We received mixed feedback from people and their relatives regarding staffing levels. People told us there were enough staff and they did not have to wait for support. However, some relatives told us the service would benefit from more staff, as staff appeared very busy.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had not taken enough action to resolve the shortfalls identified at the previous inspection. At this inspection they remained in breach of the regulations relating to safe care and treatment and good governance.
• The provider had failed to establish effective quality assurance processes. The home manager had implemented some audits since the last inspection. However, these had not identified the issues we found during this inspection. For example, the home manager was unaware that one person had unexplained bruising. Furthermore, this had not been reported.
• There was no effective system for analysing, investigating and learning from incidents. This failure meant opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the risk of harm.
• The provider had not established a system of quality performance checks or ensured staff had completed necessary training to support them to deliver safe care to people.
• The provider had a series of policies in place. However, these were not always followed by staff and did not adequately reflect practice within the home. For example, the use of Closed-Circuit Television (CCTV) policy stated warning signs were placed in all areas where CCTV was operational. We found there were no signs or notices present within the service to notify people of CCTV.

People were at risk of harm as governance systems and processes had not been fully established and operated effectively. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider did not understand their responsibilities under the duty of candour.
• During this inspection, we identified several incidents that had not been reported to CQC or to the Local Authority. This was identified as an area for improvement at the last inspection.
• Following this inspection, the home manager confirmed they had notified both agencies of these incidents retrospectively.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives told us the home manager was approachable. Comments included, "[Name of manager] is very easy to talk to" and "[Name of manager] is absolutely lovely. Sometimes when I phone to find out how my [relative] is, [name of manager] has no problem taking the phone so I can speak to the people caring for my [relative], it's a real positive and a big improvement."
• Staff told us they enjoyed their jobs and they felt confident approaching the home manager if they had concerns. One member of staff told us, "I like working here. [Name of manager] is amazing, she's all for the residents. If I had concerns, I would report it straight to [name of manager]."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
•The provider had engaged with people and their relatives through satisfaction surveys. However, the responses from these were limited and the results had not been analysed.
•One residents' meeting had taken place since our last inspection. However, we received mixed feedback from people about opportunities to give their views on the service. For example, one person told us, "I'm not asked for my opinion, but I just sit here quietly."
• Two staff meetings had been held since our last inspection. Staff we spoke with told us they felt able to raise concerns with the home manager and they would be listened to.
• The service worked in partnership with relevant health and social care professionals. We received positive feedback from a visiting professional about improvements they had seen in relation to staffing levels.