

Roborough House Ltd

Roborough House

Inspection report

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Tel: 01752700788

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Roborough House is a nursing home providing personal and nursing care for 38 people at the time of the inspection. The service can support up to 44 people. Roborough House supports people with a range of complex needs around their mental and physical health. The service is in a large detached building split into three units with their own communal areas, over two floors with a lift for people who may have mobility needs. The service is set in its own grounds, on the outskirts of Plymouth close to the moors, and has an indoor activities space.

People's experience of using this service and what we found

Medicines were not always managed safely. Improvements had been made recently but there were still errors in administration, recording and some decision making was not documented. Risks that people faced were not always assessed and clear guidance on how to mitigate risks was not always available for agency or new staff. The service had several areas that needed improving and the management team had a plan to address these. However, they were not aware of some of the concerns identified during the inspection and quality and audit processes needed strengthening and embedding in to the day to day running of the service.

Some improvements were needed to the environment as it was showing lots of signs of wear and tear. Improvements had been planned as part of a programme of refurbishments. People were having their care needs met but staff felt rushed and struggled to sometimes support people with their care.

Recruitment processes were robust, and several checks were made to ensure staff were safe to work with people who might be vulnerable. Staff knew people and their needs well and we saw positive interactions and people smiling and happy to see staff. People told us they felt safe and liked living in Roborough House. Relatives gave positive feedback about the service and how safe it was. Safeguarding concerns were reported and acted upon promptly.

Staff reported the culture in the service was changing for the better, they felt supported and the new management team were approachable and listened to them. Relationships with health professionals had improved and communication was good regarding the needs of people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We have made a recommendation about staffing levels and monitoring of the environment. We identified breaches of regulations regarding safe care and treatment and good governance.

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 (published 14 March 2018).

Why we inspected

The inspection was prompted in part due to concerns received about areas of concern such as medicines, staffing and incidents. A decision was made for us to inspect and examine those risks. 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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this focused report. You can see what action we have asked the provider to take at the end of this full report.

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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roborough House on our website at www.cqc.org.uk.

Follow up

We will request an action plan from 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Roborough House

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

The inspection team consisted of one inspector, one member of the medicines team, one nurse specialist adviser and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Roborough House 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 did not have a manager registered with the Care Quality Commission. However, the manager in post had started the registration application process. A registered manager 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 announced. We gave short notice of the inspection as some people may have been upset by having strangers in their home. We also wanted to check if there were any people who had tested positive for coronavirus or had symptoms before entering the premises.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and 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. 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 used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service and thirteen relatives about their experience of the care provided. We spoke with five members of staff including the deputy manager, manager, operations director and registered nurses on the site visit.

We reviewed a range of records. This included five people's care records and supporting charts and notes. We reviewed 24 medicine administration records, care plans and daily care notes relating to medicines. We looked at medicines storage and spoke to two members of staff. We reviewed medicines governance records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the day to day management of the service, including infection control processes, environmental checks, fire safety, and monitoring charts were reviewed.

After the inspection

We received feedback from seven care and domestic staff and five professionals that work with the service. We continued to seek clarification from the manager to validate evidence found. We looked at key policies, incident recording and quality assurance records.

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 requires improvement. 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

- Individual risks some people faced were not assessed. For example, identified risks the management team told us about regarding long term alcohol use and heightened behaviours had no corresponding risk assessments.
- For a person at risk of complications from their continence needs, an identified management strategy was not being completed. Records showed bowel monitoring was not recorded or followed up when a potential issue arose. The person had come to no harm from this but had been placed at risk of avoidable harm.
- Some people may be at increased risk of harm from fire because they had emollient creams applied and smoked cigarettes. This had not been identified in risk assessments or included in Personal Emergency Evacuation Plans.
- Guidance for staff on how to support people to mitigate risks were not in place for some of the care documents we looked at. Care staff knew people's needs well but there was limited guidance for agency or new staff on how to support some people with specific aspects of their care.
- Incident records did not reflect some incidents of choking in daily care notes. This meant the risks this person was facing could not be robustly assessed for themes, as the management team were not made aware of them through incident reporting processes.

Using medicines safely

- The manager had improved the way medicines were managed in the home, but further work was needed to make sure that people received their medicines safely.
- Staff ordered, stored and disposed of medicines safely and effectively. However, medicines were not always given as prescribed.
- Most medicines administration records (MARs) were accurate, but we saw some gaps where it was not possible to tell if a medicine had been given. Some handwritten MARs did not have all the required information to make sure a medicine was given safely. Some MARs showed that people often missed doses of medicines.
- Care staff had guidance about where to apply creams and other external preparations during personal care. However, staff did not always sign the MAR after applying medicated creams.
- Nurses used their clinical and professional judgement to decide if a 'when required' medicine was needed. There was no guidance in place to make sure they made consistent decisions. The reason for giving a 'when required' medicine, and the outcome were not always recorded.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

- The environment needed improving as it was showing signs of extensive wear and tear in parts. The manager and provider were aware of concerns around trip hazards from uneven flooring, damaged patio area and broken tiles in bathrooms. There was a schedule of improvement works planned. Staff feedback regarding the environment included "Well it's not the best, things get broken and it takes weeks to get replaced."
- Several issues required immediate attention such as a hole in a wall, an unrestricted window when there was a recent history of people absconding, and several broken radiator covers exposing splintered wood. We intervened and asked for these areas to be made safe. On our second day the window restrictor had been fitted and hole in the wall fitted but the damaged radiator covers had not been replaced.

We recommend a robust system of environmental checks is introduced to identify and act on environmental hazards.

- There were plans to renovate bathrooms to make them easier, safer and more pleasant for people to use.
- Some risk assessments were clear, accurate and gave clear instruction to staff on how to support people with the risks they faced or posed to others.
- Some people were living with complex and multiple health conditions. Staff worked with other healthcare professionals to make sure the right medicines were prescribed, and referrals were made to support their health and wellbeing.

Staffing and recruitment

- Every staff member we spoke with fed back there could be more staff, in particular on the ground floor Maristow unit where several people required support from two staff and often there were only two care staff on shift. One staff member said, "If we had more staff, we would have more time with everyone and be able to pay attention to detail."
- People told us there were enough staff and staff were always available. We did not see evidence of how staffing levels were placing people at risk. However, we did hear, for example, supporting people to have a shave or a shower rather than a wash was pushed back due to staff being "rushed off of their feet." Staff said, "Everyone gets washed and dressed and are clean, but we should be doing more than that and not just meeting basic needs" and "I feel rushed during personal care and that isn't fair on the residents."

We recommend staffing levels are reviewed to ensure they consider the individual needs of people and the complex layout of the building.

- Recruitment processes were robust and included application, interview, induction and probation stages. Police checks were completed to check if potential staff were safe to work with people who might be vulnerable.
- Staff were visible when we visited in communal areas. People who required one to one staffing to meet their needs, had this in place.

Systems and processes to safeguard people from the risk of abuse

- Relatives told us "Staff maintain a balance between dignity and safety" and every person we spoke with told us they felt safe.
- Safeguarding processes were robust. Concerns were reported in a timely manner, recorded and investigated thoroughly.
- The managers and staff had a good grasp of what abuse looked like and how it might present for people

living in the service. Staff had completed safeguarding training and it was discussed regularly with them.

- Where required, decisive action had been taken to safeguard people from harm.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were mostly assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach and link in with support from a local infection control professional.

Learning lessons when things go wrong

- The approach of the manager was open and honest when mistakes were made. This was being encouraged within the staff team.
- The manager and deputy manager were able to show us where lessons had been learned and a change in approach led to improved care. For example, rotating one to one staff when a person's behaviour showed signs they wanted a change.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. There had been several changes in management in the service and the culture in the service 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

- There had been several changes in leadership in the service which had created inconsistency in the quality of and monitoring of care provided. A new manager had been appointed who had started the registration process and made several improvements as reported by staff, relatives and professionals. However, there had not been a consistent period of improvement in the service and the service needed longer to embed positive changes in to the staffing culture and practise.
- The manager knew there were several areas that were not in keeping with regulatory requirements and was open and honest about these. However, systems and processes were not yet robust enough to identify some areas of improvement. For example, environmental checks had not identified the hole in the wall, splintered wood or unrestricted window. The medicines audits had made improvements in some areas but not identified inconsistencies in administration. Risks were not all assessed or updated.
- A new management team had been recruited and staff were clear on the service hierarchy, and who they could go to for support. However, some further work was being done to support nursing staff and care staff to better understand what their responsibilities were and what they were accountable for on shift.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager and deputy manager had improved medicines governance processes. A regular audit of medicines process identified areas for improvement which were then acted upon.

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

- All staff we spoke with told us of an improvement in culture and atmosphere due to the approach of the management team. They said, "Since the managers have started the difference, they have made is amazing" and "They are so approachable I can go to them any time."
- We heard of several positive outcomes people had been supported to achieve such as reducing alcohol intake and becoming more independent with personal care and mobility.
- We discussed with the manager how they were going to approach supporting the team to communicate more openly with each other so positive outcomes could be evidenced. They said they were going to continue to lead by example, delegate effectively, and ensure staff placed people at the centre of the service.

- Relatives said the managers had made regular contact with them and were "Hands on and very visible" and "Improved mine and my [relative's] quality of life."

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

- Incidents were reported as needed and people, relatives and professionals kept informed.
- When we discussed the duty of candour with the manager, they showed their understanding of their responsibilities in this regard.

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

- People were consulted about changes in the service. For example, colours to redecorate communal areas had been chosen by people living in the service.
- Formal methods of capturing feedback were being developed. However, people and relatives told us their views were sought on different aspects of the service.
- Refurbishments considered people's mobility needs and how their mental and physical health affected them day to day. For example, new flooring had been planned that would not be confusing for people living with certain dementia diagnoses.
- Staff told us they felt listened to and their ideas were sought. They said, "They take what we say on board and don't take sides."

Continuous learning and improving care; Working in partnership with others

- Professionals fed back, communication with the service was good and relationships were improving. Professionals said, "I have found communication to be open, clear and timely" and they found the management team to be "Pro-active and transparent."
- The attitude of the management team was open and took constructive feedback positively. There was a keen desire to improve the service for people living there.
- Training opportunities were being explored to upskill the staff and improve their confidence.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not always managed safely. Risks were not always robustly assessed or mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to check the safety and quality of the service were not robust.