Roborough House Ltd

Roborough House

Inspection report

Tamerton Road
Woolwell
Plymouth
Devon
PL6 7BQ

Tel: 01752700788

Date of inspection visit:
13 January 2016
14 January 2016

Date of publication:
01 April 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 13 and 14 January 2016 and was unannounced.

Roborough House provides care and accommodation for up to 51people. On the day of the inspection 42 people were using the service. Roborough House provides nursing, rehabilitation and residential care to people with mental and physical health needs including acquired brain injury and degenerative conditions.

The service had a new manager in post that started at Roborough House in October 2015. The new manager was going through the Care Quality Commission registration process to become the registered manager.

People's medicines were not always managed safely. People had not always received their medicines as prescribed and there were gaps in people's medicines administration records. People's regular medicines were not always in stock; this meant some people did not have their medicines when they required them as prescribed.

People's care records including their risk assessments were not reviewed frequently or as their needs changed. Records were not well organised, information was held in different places, gave conflicting instructions about people's care and staff found it difficult to find information when they needed it. Staff told us they did not have time to update people's care records.

There were quality assurance systems in place but these had not been effective over the past year in maintaining the quality of the service. The service had an open and transparent culture. Staff felt listened to and able to contribute ideas to the development of the service to drive improvement.

Staff received a comprehensive induction programme which included shadowing more experienced staff. There were sufficient staff to meet people's needs; however there was a reliance on agency staff at the time of the inspection. There was a physiotherapist and occupational therapist to complement the staff team. Some staff had not completed training deemed as essential by the provider which meant there was a risk of them not providing care based upon best practice. We observed staff used the correct techniques to transfer people and staff demonstrated good communication skills and most staff had a good knowledge of the people they cared for.

People were relaxed throughout our inspection. There was a busy but pleasant atmosphere. People were seen laughing, engaging in activities and we saw kind, patient interactions between people and staff. People and relatives told us the care was good at the home and people enjoyed living in the home. Some people had lived at the home for many years and they were happy.

People were promoted to live full and active lives where possible and were supported to be as independent as they could be. Activities were meaningful, individualised and reflected people's interests, the seasons and their hobbies.

People consented to their care and treatment and the correct legal processes were followed if people were unable to consent to their care.

People were supported to maintain good health through regular access to health and social care professionals, such as GPs, social workers and mental health nurses.

People and their relatives told us they felt safe. All staff had undertaken training on safeguarding vulnerable adults from abuse. Staff displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff confirmed they felt confident any incidents or allegations would be fully investigated.

People were protected by the service's safe recruitment practices. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment.

People and those who mattered to them knew how to raise concerns and make complaints. People told us they had no concerns. The manager informed us any complaints would be thoroughly investigated and recorded in line with the complaints policy.

Staff, relatives and external professionals described the management as supportive and approachable. Staff talked positively about their jobs and the new manager.

Incidents were appropriately recorded and analysed. Learning from incidents and concerns raised was used to help drive improvements and ensure positive progress was made in the delivery of care and support provided by the service. Staff and team meetings were used to reflect on incidents and consider preventative measures to reduce the likelihood of similar situations occurring again.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not managed safely. People did not always receive their medicine when they needed them as medicines were not always in stock.

Safe recruitment practices were followed and there were sufficient numbers of skilled staff to meet people's needs but there was a reliance on agency staff which meant people's care was not always provided by people who knew them well.

People's skin and nutritional risk assessments were not reviewed frequently which placed them at risk of skin breakdown and not having their nutritional needs met.

Staff had a good understanding of how to recognise and report any signs of abuse, and the staff took action, where needed, to protect people.

The environment was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain a healthy balanced diet but the care plans and records relating to people's dietary needs were not always an accurate reflection of their nutritional needs. This meant people who required food and fluid intake monitoring were at risk as their dietary intake was not always known.

People experienced positive outcomes regarding their health. The staff engaged proactively with health and social care professionals, and took preventative action at the right time to keep people in the best of health.

People's human rights and legal rights were respected. Staff had received training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been

followed in practice.

The provider had an essential training programme in place for staff to ensure the competency of staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People's care needs and histories were not always known by all staff. This meant care might not be provided in the way people liked or required for their health.

The staff were kind.

People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and staff.

People were informed and actively involved in decisions about their care and support. Advocacy services were available to people.

End of life care was compassionate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were personalised but had not been updated and reviewed so they did not always reflect people's current needs. Staff did not always know people's preferences and some staff had not read people's care plans. This meant people may not receive care responsive to their needs.

Most staff knew how people wanted to be supported and we observed staff providing care the way people liked.

Care planning was focused on a person's whole life. Activities were meaningful and were planned in line with people's interests.

People were encouraged to maintain hobbies and interests. Staff understood the importance of companionship and social contact.

There was a complaints policy in place. People knew how to

raise a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were in place but the lack of a stable management team in 2015 had affected areas of care provision and service quality. Audits identifying problems within the service had not been promptly addressed. However, the new manager was working hard to address these areas.

There was an open culture. The management team were approachable and defined by a clear structure.

Staff were motivated and inspired to develop and provide quality care.

Communication was encouraged. People and staff were able to make suggestions about what mattered to them.

Roborough House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The unannounced inspection took place on 13 and 14 January 2016. On the 13 January 2016, one inspector for adult social care, two pharmacist inspectors, a specialist advisor and an expert by experience visited the service. On 14 January 2016 the inspection was undertaken by one inspector for adult social care and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered general nurse.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with nine people who used the service, one relative, the manager, the deputy manager and seven members of staff.

We toured the premises and observed how staff interacted with people throughout the two days. We looked at six records related to people's individual care needs and nine people's records related to the administration of their medicines. We discussed staff recruitment, staff supervision and appraisal with the manager, reviewed training records for all staff and records associated with the management of the service including team minutes, residents' meeting minutes, quality audits, policies and maintenance checks.

Requires Improvement

Is the service safe?

Our findings

People's medicine management was not safe in all areas. When people were prescribed medicines 'when required' there was not always clear guidance for staff. One person was prescribed a medicine to be given when required for seizures, but there was no guidance about how or when this should be given, or when to call for medical attention for this person. The lack of guidance meant this medicine and other people's 'when required' medicine may not always be given consistently.

Records were kept of medicines received into the home but there were no records of medicines sent for disposal. This meant that a full audit trail was not available to show how medicines were handled in the home. This was being addressed by the lead nurse for medicines in the home.

It was not clear from people's medicines administration charts whether they received their medicines in the way prescribed for them. Six people had one or more gaps on their medicines administration record (MAR) where staff signed to say medicines had been given. It was not always possible to tell whether these medicines had been administered. There were three doses of medicine left in blister packs which had been signed by staff as given to people. This meant correct medicine administration procedures were not always being followed.

One person's chart recorded three of their regular medicines as being out of stock for seven days or more, and there was no evidence that the doctor had been consulted, or the pharmacy contacted when supplies did not arrive on time. This meant that this person did not receive their prescribed medicines.

One person was prescribed a reducing course of medicine. When we checked the number of doses remaining in the pack, there were more doses left than there should have been, if all of the doses signed for, had been given. This meant that this person cannot have received their course of medicine in the correct way. This person had a note in their records that on one night an extra dose of a sleeping tablet had been given, even though it had not been prescribed for them. We informed the manager who took action to address this and informed the relevant authorities.

One person's pain relieving patch which was due to be changed every week, had not been changed for two weeks, although supplies had been ordered in and were available in the home on the day the change was due. This meant they could have been in pain which was avoidable.
Changes and improvements were being made to the way medicines were managed, however, at the time of the inspection people's medicines were not managed safely.

Another person had not received their medicine for their mental health for seven weeks between the end of November 2015 and January 2016. They had recently returned from mental health inpatient care. Their medicine was prescribed when they returned to Roborough House and they received one dose (the medicine was due every two weeks). This person did not receive their medicine on the next occasion it was due because it had not been stored according to the manufacturer's instructions in that it had not been kept refrigerated therefore was likely to be ineffective. On the second day of the inspection, which was seven

weeks on from the missed dose, we asked staff to follow this up with the pharmacy. Staff told us and records noted the person was becoming more agitated (they were receiving one to one care). We followed this up with the manager after the inspection and were told the person had received their medicine on 17 January 2016. The communication between staff regarding who was consulting with the person's doctor and chemist about this was not clear and the person was placed at risk of a relapse of their mental health, increased agitation and distress. When the medicine arrived on the second day of the inspection staff were going to administer the injection required but had not been trained in the procedure required for this specific medicine. This meant there was the possibility of it not being administered correctly.

We found medicines were not managed properly and safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely and securely.

People were given their medicines using a safe method, when we watched the lunchtime medicine round. One person looked after their own medicines and this had been assessed as safe for them to do this, although this had not been reviewed since February 2015. One person was being given their medicines covertly. We saw that this had been assessed and clearly recorded that it had been considered to be in their best interest by the relevant people.

There were clear recording systems in place for the application of creams or other external preparations. Guidance was available for staff as to how to apply these preparations for each person.

The medicines policy was currently being reviewed to make sure it followed current good practice guidance. We were told that training in safe medicines handling was being updated and reviewed and that checks would then be completed to make sure staff were competent administering medicines safely.

Risk assessments were in place to identify health concerns such as people at risk of falls, skin damage or malnutrition. People's risks were discussed and plans and ideas shared amongst staff in multi-disciplinary team meetings, to help enable risk reduction. However, in five of the six care records we reviewed people's risk assessments were not in date and not reflective of their current risks.

Care plans did not reflect the current care people needed and staff were not always sure of people's care needs. For example one person had lost a substantial amount of weight (13kgs). In May 2015 care records stated they weighed 69.8 kgs and their weight in January 2016 was recorded as 56.8 kgs. Their risk assessment was not up to date and did not reflect this and their care plan said they were taking nutritional supplements three times a day. We spoke to two staff that were providing one to one care to the person. One staff member told us the person had supplements for their weight three times a day; the other said they were not on any food supplements any more. The care plan gave three different timescales regarding how often the person should be weighed with no indication which was correct. The lack of clear guidance for staff and poor record keeping could put the person at risk of additional weight loss.

Risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt there were usually enough staff on duty to meet their needs and keep them safe. At the time of the inspection there were 38 people with nursing needs and four people who had residential care needs. Throughout the two days of the inspection nursing staff were extremely busy. We

observed staff were caring for people but they told us their other responsibilities in relation to their role, such as care planning, were difficult to maintain.

The new manager who had started in October 2015 was going through the registered person's process with CQC. They told us there were current vacancies including a head nurse vacancy. The manager was using agency staff to support the nursing team. Wherever possible they requested the same agency staff who knew people and the service. They were aware the nursing team was under pressure and systems were not as efficient and effective as they could be. The manager was also covering some of the nursing shifts at the time of the inspection which had an impact on their managerial responsibilities. We were informed by the manager, an agreement had been given by their line manager to advertise the senior nurse vacancy and look at a short term agency nurse contract whilst recruitment occurred. The goal of the management team for the future was to use minimal agency staff so people received care from staff they knew well. Following the inspection we spoke with the regional manager who supported this view and informed us a clinical services manager post was due to be advertised to bridge the gap between the nursing team and management team This post would provide leadership to the nursing staff team.

People were supported by suitable staff. Safe recruitment practices were in place and appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. The manager told us staff also completed an annual disclosure to assure the service of staffs' continued good character.

People moved freely around the home and were enabled to take everyday risks. The service had a positive risk taking culture. People were promoted to be as independent as possible whilst ensuring they were as safe as possible. The service actively looked for ways to improve areas of practice to make care more safe for example the occupational therapist had developed a high risk falls procedure and improved the bed rail safety assessment.

Staff commented how some people had behaviours which could impact on others, such as shouting out. Staff were mindful of the impact this behaviour might have on others and how this could place the person at risk. Behaviour charts were used to identify the antecedents and triggers of people's behaviour to reduce risk and keep people safe. Staff monitored these people's incidents and their GP / care teams were involved in reviewing their care where required. For example altering people's medicine times to improve their quality of life or providing additional resources to keep people safe.

People were protected by staff that had a good awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Some staff had received safeguarding training through the local authority and through in house e-learning but some had not. This meant they may not recognise safeguarding and know how and what to report. Some staff knew who to contact externally should they feel that their concerns had not been dealt with appropriately but other staff were less confident with local reporting procedures. Incidents of safeguarding were investigated and discussed with the relevant authorities openly and honestly.

People were protected by staff that managed and controlled the prevention of infection well. A dedicated cleaning team and laundry assistants were employed. All areas of the home were clean and smelled fresh. Staff understood their role, used protective equipment for personal care and followed policies and procedures that reflected current guidance on keeping people safe from infection. Staff told us they were trained in infection control and when an outbreak occurred they would use barrier nursing. Barrier nursing is a set of stringent infection control techniques used in nursing. The aim of barrier nursing is to protect staff

and other people living at the service against infection by people with highly infectious diseases or illnesses.

The staff team at Roborough House had made improvements to people's safety over the past few months including the purchase of a defibrillator which would enable timely care in an emergency situation. A protocol had also been developed by the occupational therapist for people at high risk of falls and this was being incorporated into people's care plans. The protocol gave consideration to people's equipment, medicine and indicated where referrals were required in order to reduce the likelihood of falls. The occupational therapist had also reviewed and updated the bed safety rail assessment tool based on latest research. This made care safer in this area. People's safety was important to staff at Roborough House and learning from incidents which had occurred was integral to the home. For example following a recent investigation, the pre admission form was changed to reflect people's seizure history and a flow chart was designed to support staff decision making and detailed actions required if someone had a seizure.

Requires Improvement

Is the service effective?

Our findings

Most people were protected from the risk of poor nutrition and dehydration by staff that regularly monitored and reviewed people's needs. People's nutritional needs were discussed in the nursing team meetings where there were concerns or improvements seen. We were told this information was shared with kitchen staff to improve their dietary intake. Staff told us people were weighed regularly and weight changes monitored closely. Staff liaised promptly with family and people's doctors if there were concerns. Some people had been referred to the Speech and Language Team (SALT) for assessments where there were concerns their health needs impacted on their diet. Staff were aware of those people who required a soft or pureed diet and followed guidance given by the healthcare professionals involved. However, we found people's care plans and risk assessments were not always reflective of people's current nutritional care needs and there were gaps in food and fluid recording charts, for example one person whose food and fluid intake was being monitored had nothing recorded for two days. This meant it was not clear from the charts whether the person had eaten or drunk anything for 48 hours.

Accurate and complete records were not kept in relation to each person, including a record of the care and treatment provided to the person and decisions taken in relation to the care and treatment provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives where appropriate, were involved in discussions and decisions about what people liked to eat and drink. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet however we found staff were not always aware what was written in these records. For example we read one person disliked chicken but staff and the cook did not know this.

People's day to day needs were met by staff that monitored, discussed and reviewed their health needs frequently. However, these reviews were not always recorded in people's care records to enable changes over time to be noticed and the appropriate action taken. Behaviour charts monitored people's individual needs where this was necessary. A weekly nursing team meeting reviewed people living at the home, discussed any health concerns / improvements, referrals to other professionals that were needed or upcoming hospital reviews. A range of external health professionals supported people's health needs such as GPs, opticians, dentists, chiropodists and mental health professionals. When positive changes were made to people's health and they no longer required the level of care Roborough House provided, the staff team ensured prompt referrals were made to support people to move on to alternative accommodation or independent living if appropriate.

Staff confirmed they received a thorough induction programme and on-going training to develop their knowledge and skills. They told us this gave them confidence in their role and enabled them to follow best practice and effectively meet people's needs. Newly appointed staff shadowed other experienced members of staff until they and the manager felt they were competent in their role. The manager told us, staff could openly discuss and request additional training and would be supported to achieve their goals. In the past year staff had engaged in communication training, supervision workshops and equality and diversity

training.

The manager confirmed they were aware of the new care certificate, recommended following the 'Cavendish Review,' and were implementing this for all new and existing staff. The aim of the care certificate is to improve consistency in the training health care assistants and support workers receive in social care settings.

Staff had been encouraged to complete the provider's essential training and once a week, additional staff were rostered to enable staff to have protected time to do this. Staff were clearly able to explain how they would respond to different situations. For example, if they found a person with skin damage or discovered someone had fallen.

Staff training and development needs were identified through formal one to one meetings, informal discussions, observation of care and staff meetings These mechanisms were seen as important to share learning, knowledge and good practice and support staff new to care work. Supervisions, one to one meetings with senior staff, were undertaken and the new manager had met with all staff. This was valued by staff as the service had been without a manager for some time. Annual appraisals were planned to enable staff reflection of their performance over the past year and consider the year ahead. Open discussion provided staff the opportunity to highlight areas of good practice, identify where support was needed and raise ideas on how the service could improve.

We spoke with the manager during the inspection feedback about increasing the skills of the care staff to support the nursing staff and provide more effective care. For example we met one person who required suctioning to reduce the risk of them choking. Only nurses could do this at the time of the inspection. This therefore meant, when there was only one nurse working, they were occupied doing this task. The occupational therapists and physiotherapists employed by Roborough House had successfully taught the care staff to support some people with their exercises under their supervision and guidance.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Care records showed where DoLS applications had been made and evidenced the correct processes had been followed. Health and social care professionals and family had been involved in the decision. The decision was clearly recorded to inform staff. This enabled staff to respect the person's legal status and helped protect their rights. The manager had a good knowledge of their responsibilities under the legislation and had undertaken training in this area.

Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. We heard staff discuss more complex situations where other professionals might need to be involved in deciding what was in a person's "best interests". Staff told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to wear or drink. However, when it came to more complex decisions such as a do not resuscitate order or where the person should live, a health care professional or, if applicable, a person's lasting power of attorney in health and welfare was consulted. Where necessary, Independent Mental Capacity Advocates (IMCAs) were also used to support decision making, to ensure people's right were protected. Independent Mental Capacity Advocacy was introduced as part of the Mental Capacity Act

2005. This gives people who have an impairment, injury or a disability which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation.

Requires Improvement

Is the service caring?

Our findings

There was a lack of consistency in the caring approach of staff. Care plans did not always reflect people's needs which meant care may not be provided in people's preferred way and staff may not have the information they required to care for people. Not all staff had read people's care plans which meant they did not know the details of how people liked to be cared for. Agency staff told us they felt they did not always have sufficient information about the people they were caring for, for example their backgrounds and personal histories. The care information which was kept with people receiving one to one care did not always reflect their main care plan or their current needs. This meant staff may not be providing the care and support the person required.

People were cared for by staff that showed concern for their wellbeing in a meaningful way. We saw staff interact with people in a caring, supportive manner and took practical action to relieve people's distress. For example we observed staff doing a dressing for one person with a wound, the wound was sore and this caused the person pain. Staff were gentle, kind and reassuring as they did the dressing. However, we found pain scales and discussions related to improving the person's level of pain whilst the dressing was changed had not been done. This may have improved the level of pain the person experienced during the dressing change. We spoke to the manager about considering the person's pain relief prior to this dressing being undertaken to relieve them of possible distress.

We found care was not always person-centred or reflective of people's personal preferences for care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who generally knew them well. Some staff were able to tell us about individual likes and dislikes, which matched what people and their care records told us. When the care plans had last been updated they were written in a personalised way and had good information on people's backgrounds and histories including details of how people liked to be cared for.

People and those who mattered to them were positive about the caring nature of the staff. Everyone spoke highly of the quality of the care and confirmed they were treated with kindness. Staff were respectful to people, cheerful and positive in their interactions and people told us they felt listened to. Comments included, "Staff are polite, kind and caring" and "I can speak for myself and put across my needs;" and "They talk and listen, get anything I need, they will do shopping for people too."

Some staff had been employed for a long time at Roborough House and had developed strong, caring relationships with people. For example, one person showed signs of distress whilst walking in a corridor. A staff member promptly assisted the person. They spoke with the person in a kind manner, asked the person where they would like to go. They offered choices of what the person may have wished to do and then supported the person in the decision they made. Within a short space of time we saw the person became more relaxed and were planning to go shopping with staff.

People told us they were treated with respect and dignity. Pleasant conversations were held during lunch

and we saw staff asking people how they would like their hair styled as they relaxed in the lounge area. People gave examples of staff knocking on their doors before entering, addressing them politely in the way they wanted to be spoken with and covering them when providing intimate personal care. One person told us "I am treated with a lot of dignity and I can ask for the staff I want to do my personal care." Another person said "I have a good banter with staff. Staff are respectful and I can tell them how I want to be cared for." We saw in care records that people's preference for male or female care worker was noted. There was a Dignity, Respect and Choice policy in place and most staff had undertaken equality and diversity training. People were supported by staff that knew their individual communication needs, and were skilled at responding to people appropriately. Staff talked to people in a way they could understand and helped people communicate their needs. The occupational therapist described how they communicated with one person whose health needs made their speech difficult to understand. This person found it hard to find the right words so staff worked hard to narrow down the subject topic and possible words to communicate with them.

Staff told us they demonstrated they were caring by "Doing what I say I will do and trying to make sure I follow up people's requests". Staff told us the activities team were particularly caring saying, "Amazing", "[X's] compassion is extraordinary; they notice everything and know everybody."

Friends and relatives were encouraged to visit, be a part of the family and friends meetings held at the home. The manager told us and relatives confirmed, they could visit at any time and were always made to feel welcome. People had been encouraged and supported to remain in touch with friends and family through the use of technology and social media.

Advocacy services were welcomed at Roborough House and involved in people's care where this was required. The advocacy service had been to talk to people at one of the residents' meetings.

People were supported to have a dignified end of life. One person at Roborough House had recently returned from hospital and was receiving end of life care. Staff were caring for them to ensure they remained comfortable and pain free. There was an end of life champion at the service and the manager told us in their Provider Information Return they wanted to improve this area over the next 12 months. We also saw this area of care was in the service's improvement plan as an area to develop.

People's confidentiality was respected and people's records were kept securely.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained detailed information about their health and social care needs. They were written using the person's preferred name and reflected how people wished to receive their care. People's personal preferences were usually known. People and where appropriate, those who mattered to them, were involved in the care planning process to help ensure their views were recorded, known and respected by all staff. However, people's care records had not been reviewed and updated as people's needs changed. Staff told us they were very busy and did not always have time to read people's care records so they knew people's strengths and levels of independence.

Not maintaining accurate, complete and contemporaneous records in respect of each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, family and health professionals where possible contributed to an assessment to ensure the service was able to meet people's needs. Staff used their communication skills such as listening and observing to understand people's individual needs and developed personalised care plans. The activity staff also contributed to the assessment process through their one to one work with people and through the group activities. This meant a holistic overview was obtained including people's social skills.

People's needs were regularly reviewed through the weekly nursing team meetings and staff handovers. Arrangements were made for health and social care staff to review people frequently or as their needs changed. Prompt referrals were made to support people's need for additional equipment such as specialised chairs or referrals to external agencies such as dieticians as required.

People and their care records confirmed people were supported to follow their interests. People were encouraged to take part in the social activities organised by the staff to reduce the risk of social and community isolation. A dedicated activities team helped keep people active. Newsletters detailed coffee mornings, outings, the dates of residents' meetings, external entertainers and people's birthdays. An aromatherapist was employed which people enjoyed, massages and aromatherapy treatments helped people to relax.

The service had a policy and procedure in place for dealing with any concerns or complaints. The manager, nursing team lead and nurses on duty were visible and approachable in the home and there was an open door policy. The policy was clearly displayed in areas of the home. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. People and family said they would be comfortable raising a concern or complaint. We reviewed recent complaints and found they had been listened to, investigated and complainants had been responded to. Where required apologies had been given and areas which required improvement had been actioned.

Requires Improvement

Is the service well-led?

Our findings

Roborough House is owned by Roborough House Ltd, which is part of a much larger provider, Caretech Community Services, which owns many residential homes in the UK.

The management team knew prior to the inspection improvement was required to medicines management, care planning, training, staff appraisals and record keeping and had started to address these areas at the time of the inspection. Governance systems were in place to monitor and audit areas once improvement had been made, however these had not been operated effectively in the past 12 months leading to people's care being compromised.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager and deputy manager took an active role running and improving the service and had good knowledge of the people and the staff who lived at Roborough House. They would be supported by a head nurse when this vacancy was filled. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Following the inspection we were told by the regional manager, a further post of "Clinical Services Manager" was created and being advertised to lead the nursing team.

The manager, who had been in post since October 2015, was in the process of applying to CQC to be the registered manager of the service. They were supported by a regional manager who visited frequently and was available by telephone / email and a deputy manager who led on governance within the home. Roles and responsibilities were being clarified within the management team; the manager had been keen to understand how all areas worked at Roborough to inform these decisions. The manager told us "It is a lovely place to work, happy, friendly staff who have been very welcoming but it has been hard work!" and "I'm approachable, they know they can come to me with problems." Since the manager started they had spent time with all the staff across the service to gain an understanding of their role. They had become familiar with the budget, rotas, training needs and supervision and felt they had a good overview of the service and the areas which required improvement. The manager had worked many of the shifts as there were nursing shortages. This meant they had been able to gain first-hand experience of the challenges and got to know people who lived at the home. However they reflected that, although this was a good way of learning the roles and understanding the service, it meant they had not been able to address some of the managerial areas that required their attention.

People, friends and family and staff all described the management of the home as approachable, open and supportive. People said "Really like the new manager, they go above and beyond but I'm worried they will burn out, I think they do too much" and "Manager leads by example, they are motivating." Staff all told us they had confidence in the management team and were glad there was a permanent manager in post again. Staff commented "They're hands on, will fill gaps when needed, open and approachable. Over New Year

they played the organ and sang, really pushed the boat out and people loved it."

The manager and deputy told us about their philosophy of individualised care, respect and choice and how through their leadership these values were shared amongst the staff team. They also told us people were at the heart of what they were striving to achieve. The manager recognised the importance of staff having knowledge in specific areas, for example an end of life champion and we spoke with them about developing this area further to relieve the pressure on the nurses. Staff told us they felt empowered to have a voice and share their opinions and ideas they had through one to one meetings with their line manager and various staff meetings. Staff felt concerns were listened to and the management team were approachable.

The staff and management team wanted to provide a quality service and felt a stable staff team and recruiting to vacancies would support this goal. Staff told us they were happy in their work, understood what was expected of them and were keen to provide and maintain a high standard of care.

The manager told us one of their core values was to have an open and transparent service. The service sought feedback from people and those who mattered to them in order to enhance their service. The manager had apologised to people when things had gone wrong or had not met people's expectations. This reflected on the Duty of Candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The home worked in partnership with key organisations to support care provision. Health and social care professionals who had involvement with the home confirmed to us, communication was good. They told us the service worked in partnership with them, followed advice and provided good support. The local authority informed us the staff had been receptive to previous safeguarding issues raised and taken action to remedy the concerns.

The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns with the manager, and were confident they would act on them appropriately.

Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes were being made as quickly as possible so that the quality of care was improved. For example, a new medicine policy was being written during the inspection, training was being closely monitored and recruitment for the head nurse was imminent. The manager and deputy manager were working together on the priorities to ensure good standards of care.

There was a quality assurance system in place to drive continuous improvement within the service but without robust leadership in place and consistent staff this had not been maintained. This included a service improvement plan (SIP). An updated SIP was sent to us following the inspection incorporating areas of feedback, this was being monitored by the manager and regional manager.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person-centred care Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care was not always person-centred or reflective of people's personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance Regulation 17(1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance Systems and process were not operating effectively to assess, monitor and improve the quality and safety of the service. Records of people's care were not always accurate, complete and contemporaneous.

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 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always provided in a safe way because risks to people's health and safety had not always been assessed and action taken to mitigate those risks; and medicines were not properly and safely managed.

The enforcement action we took:

Warning Notice