Pinnacle Care Ltd

Roxburgh House

Inspection report

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Date of inspection visit: 15 and 16 September 2015
Date of publication: 20/11/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of Roxburgh House on 15 and 16 September 2015. Roxburgh House provides accommodation and personal care for up to 36 older people who may have dementia. Nineteen people were living at the home at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our previous comprehensive inspection in November 2014, we found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. There was a breach in ensuring sufficient numbers of staff to meet people's needs safely. There was a breach because people did not always consent to their care and support. There was a breach in meeting the legal requirements for assessing and monitoring the quality of service provision and because risks to people were not always properly managed at the home. As a result of the third breach, we imposed a Warning Notice for the service to make improvements. We undertook a focused inspection on the 14 April 2015 to check that the service had made the improvements related to the Warning Notice and found that the requirements of the

Summary of findings

Notice had been met. However there remained three existing breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008.

Following our inspection in November 2014, the registered manager sent us an action plan outlining how they would make improvements. During this inspection we found there had been some progress in addressing the actions required following our last two inspections, but sufficient improvements had not been made. We found the registered manager and the provider had not acted in accordance with their action plan.

The provider had not ensured that effective quality assurance processes were in place in order to assess and monitor the quality and safety of the service people received. This meant that a number of shortfalls in relation to the service people received had not been identified.

The provider did not always follow best practice guidance and we found that improvements had not been carried out as requested by other agencies such as the local authority and the local clinical commissioning group.

During the inspection we found there were significant staffing vacancies and staffing arrangements were not sufficient to enable staff to manage risks and meet people's needs safely. We observed instances where staff were not available to meet people's needs.

We observed instances where people were put at risk because risks to their health and safety were either not identified or were identified but not managed properly.

The provider did not make sure the premises were properly maintained and kept clean. There was no effective system to prevent and control the risks of infection and improvements were needed in managing medicines.

People felt safe with care staff and staff followed the provider's procedures to protect people from the risks of abuse. People were positive in their comments about the staff, however we observed people were not always treated with compassion and their privacy and dignity was not always maintained. Staff were aware of their responsibilities under the Mental Capacity Act (2005), however improvements were still required in staff asking for people's consent. Staff received training in all key areas of practice, however there was no evidence to confirm that training improved the way people were supported. Staff did not always respect people's choices.

Care plans were sometimes not sufficiently detailed to support staff in delivering care in accordance with people's preferences and needs. There were limited social activities which did not always reflect people's interests and hobbies.

People were supported to maintain their health and were referred to health professionals where appropriate. People were offered a choice of nutritious meals, however support for people with complex needs was not provided consistently to allow them to eat their meals safely.

We found a number of 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 overall rating for this service is 'Inadequate' and the service will therefore be placed in 'Special measures'.

While we were considering the options for enforcement action against the provider, the provider sent us an application to de-register the service. The provider assured us they were already working with the local authority to support people to move to suitable, alternative homes.

Summary of findings

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.

Staffing arrangements were not sufficient to enable staff to manage risks and meet people's needs safely. The provider did not have an effective system to prevent and control the risks of infection. The provider did not make sure the premises were properly maintained and kept clean. Improvements were needed in managing medicines. People felt safe with care staff and staff followed the provider's procedures to protect people from the risks of abuse.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were aware of their responsibilities under the Mental Capacity Act (2005), however improvements were still required in staff asking for people's consent. Staff received training in all key areas of practice, however there was no evidence to confirm that training was effective and had improved the way people were supported. People were offered a choice of nutritious meals, however support for people with complex needs was not provided consistently to allow them to eat their meals safely. People were supported to maintain their health and were referred to health professionals where appropriate.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were positive in their comments about the staff, however we observed people were not always treated with compassion and their privacy and dignity was not always maintained.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive care that was personalised specifically to them. Care records were sometimes not sufficiently detailed to support staff in delivering care in accordance with people's preferences and needs. There were limited social activities which did not always reflect people's interests and hobbies. Staff did not always respect people's choices.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that effective quality assurance procedures were in place in order to assess and monitor the quality and safety of the service people received. This meant that a number of shortfalls in relation to the service people received had not been identified. People told us the registered manager was approachable and staff felt supported.

Roxburgh 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 was 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 inspection took place on 15 and 16 September 2015. The first day was unannounced and the second day announced. This inspection was undertaken to follow up on previously identified breaches to ensure action had been taken to make the required improvements.

The inspection team consisted of two inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from other agencies involved in people's care such as the local authority, the local clinical commissioning group (CCG) and the local fire service. The local authority told us they had been monitoring the service's progress against a list of requested improvement actions. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with six people who used the service and three relatives. We also spoke with the cook, the cleaner, and three care staff including a senior carer, the deputy manager, the registered manager, the area manager and the provider.

We reviewed four people's care plans to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

Inadequate

Is the service safe?

Our findings

When we visited Roxburgh House on 10 November 2014 we found staffing arrangements were not consistent to ensure there was sufficient numbers of staff to meet people's needs safely. During this inspection we found continued concerns, where suitable arrangements were not in place to ensure there were sufficient numbers of staff to meet people's needs in a safe and timely way.

Following our last comprehensive inspection, the registered manager sent us an action plan outlining how they would make improvements. This included the introduction of a dependency tool to determine how many care staff were needed in accordance with people's needs. They told us they would ensure there were sufficient staff to have one staff member in each communal room to support people when needed. The registered manager assured us that there would always be a senior member of staff managing the home in their absence. We found that this had not been effectively implemented.

People we spoke with told us they felt there were not enough staff. Two relatives told us, "Staff seemed rushed off their feet, I wonder how they cope. People get attended to as soon as someone can," and "They could do with more staff. They try and keep people in one room so there's a member of staff." One person who lived in the home told us, "Sometimes I have to wait." Some care staff told us there was not enough staff at busy times such as mornings and evenings. The registered manager explained that by using the new dependency tool they had calculated by the needs of people who lived in the home, that they required four care staff during daytime shifts, to meet their needs. They told us the tool did not take into account the layout or size of the building. The registered manager had not adjusted the number of staff on shift to compensate for this.

We observed staffing levels to see if there were sufficient staff to keep people safe and to meet their support needs. There were 19 people living at the home and on the first day of our inspection there were four members of care staff working during the morning shift, this included the deputy manager. The registered manager was on annual leave. This meant when the deputy manager fulfilled managerial tasks, there were only three care staff to meet people's needs and this was not in accordance with the dependency tool requirements. An additional member of care staff was included on the afternoon shift from 2.30pm, which allowed the deputy manager to return to a managerial role. We discussed this with the registered manager on the second day who told us they had written the staff shift rotas and the reduction in staff on the morning shift had been an, "Oversight."

The service had significant staffing vacancies. The registered manager was in the process of recruiting two more full time care staff, a cleaner, a maintenance person and a dementia specialist to support people in their chosen activities. They used agency staff to meet staffing requirements. There was an agency cleaner and two agency care staff on each daytime shift. A maintenance person visited on an 'ad hoc' basis from one of the provider's other services. Care staff were responsible for completing cleaning tasks when there was no cleaner. They were also responsible for meeting everyone's care needs including administering medicines, laundry, preparation and service of meals and supporting people to engage in their chosen interests.

We found there were not always sufficient staff to meet people's needs. On two occasions we observed there were no care staff in a communal room, which was not in accordance with the home's action plan and placed people who required close supervision at risk. For example, on one occasion we observed one person alone in a communal room, who was anxious and shouting. Records showed this person had been assessed as being at high risk of falls and there was no member of care staff present to support them. We observed another person had not had a shave on the morning of the first day of our inspection and had told staff they wanted one. Care staff did not support this person to have a shave until late afternoon. We asked staff why the person had not been shaved. One member of staff told us, "We try and shave people on morning shifts." Another member of staff told us, "We are busy in the mornings. There are two people (staff) to get people up, one person does breakfast and the senior (carer) does medicines." This meant staffing arrangements were not sufficient to enable staff to manage risks and meet people's needs.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Records showed some risks to people's health and welfare had been identified and assessed. Care staff told us how one person's nutritional risks had been assessed. Their care

Inadequate

Is the service safe?

plans described how staff should support them to meet their needs and minimise risks to their health. One staff member explained how the person's weight was monitored and how they would refer them to their GP if they had a concern.

We found that not all risks to people's health and safety were being properly managed. We looked at the care records for one person and found risks to their mobility had been assessed and they were at high risk of having a fall. Their records showed that as part of the assessment to reduce their risk of falls, they should wear shoes or slippers. On the first day of our inspection this person had a fall in a communal room of the home. Following the fall we observed the person walking alone. We asked care staff on duty how this person was supported following their fall, however the two care staff we spoke with were not aware the person had sustained a fall. Records showed that an incident form had been completed by a member of care staff who had witnessed the fall. This showed that the incident had been identified, however the information had not been assessed or shared with other staff on shift. We found the same person was not wearing shoes or slippers. The person told us, "I love to wear them." We asked care staff why the person was not wearing footwear and one member of care staff told us, "[Name] will just take them off." The registered manager told us, "[Name] wears slippers normally and staff know to fetch them if they are not on." Therefore risks to the person's health and safety had been identified but were not being monitored or managed to reduce the persons' identified risk of falls. We spoke with the person's relative and they told us, "I worry about the stairs and [name] not being observed by staff." The person sustained a further fall on the second day of our inspection. The registered manager referred the person to the GP who reviewed them on the same day and made a recommendation the person should wear shoes. We discussed this issue with the registered manager who told us they would review the person's needs.

We observed one person wearing odd slippers with different height heels. We asked care staff why the person was wearing odd slippers, staff could not tell us. The potential tripping hazard was not identified by staff and no action was taken to reduce the risk. There was no effective system to assess and manage risks to keep people safe.

We looked at how the home was kept clean to protect people from the risks of infection. Most of the people who lived at the home were not able to tell us whether they felt the home was as clean as they would like because of their complex needs. An agency cleaner told us they worked four days per week and day and night care staff were jointly responsible for cleaning on the other days. During the inspection we saw that several areas of the home were visibly dirty and had a strong unpleasant odour. The kitchen was not clean and some surfaces were damaged so they could not be properly cleaned. For example, the back of one cupboard was missing and there were damaged tiles behind it. The back of another food storage / crockery storage cupboard was damaged. There was a hole in the wall in the dry store and building rubble debris, soil and cobwebs on the floor. Food was stored on the floor close by. There were flies in the dry store, which increased the risk of cross contamination. The swing bin and under the sink in the kitchen was dirty. We spoke with the cook who told us they had shared responsibility with night staff to clean the kitchen. They told us, "I'll try and do it. Night staff should do it." Records showed that cleaning schedules were not effective because they did not specify all areas of the home and they had not always been completed by staff.

A communal toilet was blocked on the first day of our visit. It had overflowed and there were faeces to the rim level. There was a sign on the door saying out of use, however the door was open. We saw the toilet was accessible to people until it was secured at 1.30pm by a maintenance person. It was cleaned later that afternoon. This was an infection control risk, because the toilet was accessible for people to use and it was contaminated by faeces. The unpleasant odour was smelt in the small lounge where some people were sitting.

Other parts of the home were visibly dirty including the kitchenette in the dining room, where there was food debris from the previous days evening meal, in the sink, the swing bin was dirty and the wall by the bin was dirty. High up areas of the home were also visibly dirty with cobwebs. There were some surfaces in the home that could not be cleaned, for example paper photos were stuck to walls and some carried dust and cobwebs. There was a strong smell of urine in both entrances to the home and in both lounges.

We found there were supplies of personal protective equipment (PPE) in the home, including aprons and gloves. We observed two members of care staff supporting people

to eat finger foods. Staff put food into people's mouths without wearing appropriate PPE to prevent them coming into contact with people's bodily fluids. We spoke with one of these staff members who told us they had received training in infection control and hand hygiene, they told us they did not use gloves when touching people's food, but they washed their hands. This was a risk of infection.

We found no hand towels in the sluice room or in the laundry. There was no soap in one communal bathroom. Hand towels were missing from two people's bedrooms we looked at. This meant there was a risk of infection because people could not clean their hands properly.

Care staff told us they struggled to keep the home clean. One member of staff told us, "It's a time issue really, that's why it is sometimes not done." A senior member of staff told us, "We have a room checklist, we go round and see what needs doing. It has not been done today because we are busy." Infection control audits had taken place, but they were not effective because ongoing infection control concerns such as the soil and building debris in the kitchen had not been identified. We discussed this with the provider and the registered manager who told us, "I think that might have been from the boiler we had replaced at the beginning of the year." They added they felt they required more cleaning staff, but had been unable to recruit them. The provider did not have an effective system to assess and control the risks of infection.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

We looked at how the premises were managed to keep people safe and found that they were not always properly maintained. A relative told us they were concerned about the flooring, they said, "I wonder about hazards." We found various hazards in the home, for example on the first day of our inspection we found a fire door on the ground floor was propped open, which would not protect people in the event of a fire. We asked care staff about it and they told us it was to keep the laundry cool and a member of staff closed it. On the second day of our inspection the door was propped open again. We found a metal carpet seal strip was raised in a communal corridor, creating a potential trip hazard. One member of care staff told us, "It keeps coming back up after it's been done." Although we saw action was taken to reseal the strip, there was no action taken to prevent reoccurrence of the hazard. A fire safety compliance check was carried out by the local authority on 3 September 2015. Records showed and we saw that eight deficiencies had been identified as requiring action by the provider to meet their legal responsibilities. For example, the local authority report stated, 'The premises are not equipped with appropriate detectors and alarms necessary to safeguard people' and 'The fire alarm system is not subject to a suitable system of maintenance and testing.' The registered manager sent us an action plan following our inspection, detailing how and when they would meet the legal requirements. The provider had not ensured they met the requirements of relevant legislation so that premises were properly maintained and kept clean.

This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 premises and equipment.

We looked at the medicine administration records for 11 people living in the home including the storage and management of medicines and found, overall that people received their medicines safely but there were some areas where improvements to the management of medicines were required. The service had recently changed to a dispensing pharmacy to obtain medicines. This had helped to improve the supply and availability of medicines.

We found people did not always receive their medicines as prescribed. We found one person had not been given a prescribed medicine on one occasion although their Medicine Administration Record (MAR) chart had been signed for the administration of the medicine. The medicine was still in the supplied medicine pack. A second person's MAR chart had been signed for the administration of a medicine, however it had not been given at the times indicated on their MAR chart. This had not been followed up or checked with the pharmacy or the prescribing doctor. Following discussion of this issue with the deputy manager and the area manager on the first day of our inspection, staff contacted the person's GP and the prescription was changed. The person's medicine was administered at the time shown on the new MAR chart on the second day of our inspection.

Staff told us people's medicine requirements were regularly reviewed by their GP. We found care records which documented that medicine reviews were taking place. Medicines were stored securely within the recommended temperature ranges for safe medicine storage. We found daily temperature records were available which

Inadequate

Is the service safe?

documented that the medicine storage room and medicine refrigerator were within safe storage limits. We found one bottle of liquid medicine which was very sticky on the outside and had not been wiped clean following use. This increased the potential for contamination between handling of medicines as well as a potential infection control issue. Supporting information was available for care staff to safely administer medicines. We looked at one person's record who was prescribed a medicine to be given 'as required' for agitation. Procedures were available with their MAR charts to inform care staff under what specific circumstances the medicine could be given. We found care staff followed this procedure and recorded the reason why medicine was administered.

People told us they felt safe living at the home. One person told us, "Yes I feel safe". A relative told us, "Yes [name] is safe, I have no concerns." We saw information displayed advising people who they should contact if they had any concerns about people's safety. Care staff spoken with told us they had received training in safeguarding procedures. They were able to describe different types of abuse, the signs to look for and the procedure for reporting abuse. A member of staff told us, "I would write a report and make sure my team leader or senior was aware." We found the registered manager had notified us of incidents when they made referrals to external agencies such as the local authority safeguarding team.

The registered manager checked that staff were suitable to support people before they began working in the home. This minimised risks of abuse to people. For example, we saw recruitment procedures included checks made with the Disclosure and Barring Service (DBS) prior to their employment. The DBS is a national agency that holds information about criminal records.

Requires improvement

Is the service effective?

Our findings

When we visited Roxburgh House on 10 November 2014 we found there were not always suitable arrangements to ensure people consented to their care and support. The registered manager sent us an action plan outlining how they would make improvements. This included enabling privately funded residents to obtain a local authority review of their care and treatment.

During this inspection we found some improvements had been made. Most people who lived in the home were not able to talk with us about whether they made decisions, or who should make them in their best interests, so we looked at people's care plans and observed interactions between people and care staff. We found that care staff did not always ask for people's consent before they supported them. For example on one occasion we saw a member of care staff enter someone's bedroom without knocking. This had been a concern at our previous inspection in November 2014.

We saw there were mental capacity assessments completed by senior care staff on all the care plans we looked at. We saw if people were deemed not to have capacity by staff, best interest consent forms were completed for them which identified that specified care staff could make decisions about certain things on the person's behalf. For example, everyday decisions about their care. At our previous inspection we found some people who were deemed not to have capacity, did not have their care and treatment independently reviewed. When decisions were made about their care, not all the appropriate parties were involved in making decisions in their best interests. At this inspection we found that the registered manager had taken steps to make some improvements. They were in the process of organising independent reviews with the local authority, to ensure that everyone's care and treatment would be reviewed by an independent body. We found that best interest meetings were taking place where appropriate. However some best interest decisions had not been recorded clearly on people's care plans.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The registered manager told us they knew how to make an application for consideration to deprive a person of their liberty (DoLS). The registered manager told us no-one who lived at the home was deprived of their liberty at that time. Records showed one person had been assessed as not having capacity and in their care plan it had stated they did not have, 'Any concept of their own personal safety', however they had not been assessed for DoLS. We asked the registered manager and the provider why the person had not been assessed for DoLS, they told us they would review the person's needs in line with current guidance.

Staff told us they had an induction which included training, observing experienced staff and completion of a workbook. One member of staff told us they had not worked in a care role before and they felt confident at the end of the induction to work alone. They said, "I enjoyed it. I had moving and handling training straight away." Staff told us they were supported by senior staff in regular staff supervision meetings. (Supervision is a meeting between the manager and member of staff to discuss the individual's work performance and areas for development.) One member of staff told us, "Supervision is regular and helpful. I get feedback from my manager and I can put forward anything I want, for example if I want more training." Another member of staff told us they felt able to raise concerns to their manager at supervision.

The registered manager and the provider training manager planned training to support staff's development. Training was provided by staff within the organisation and included a mixture of practical and theory based training. One member of staff told us, "When we have refreshers we learn new things and different ways of doing things, for example first aid is always changing." Staff told us that they received hands on moving and handling training and learnt how to use equipment. One member of staff told us about training they had received in the Mental Capacity Act (MCA). They explained how they supported people to make decisions in their best interests and gave an example where one person was supported by their family member to make a decision about their care and treatment. Records showed that all care staff had received up to date training in mandatory areas such as moving and handling and infection control. However following observations during our inspection, there was no evidence to confirm that training had improved the way people were supported. For example, we saw some staff supporting people to mobilise, but not using nationally recognised safe techniques. There was a

Requires improvement

Is the service effective?

risk people might not be supported to mobilise safely. The registered manager told us further training had been scheduled for all care staff in this area, which would be additional to staff's annual refresher course. Care staff told us they had received recent training falls prevention and hand hygiene, however following observations during our inspection, there was no evidence to confirm that training was effective and had improved the way people were supported.

People told us they liked the meals. Two people told us, "I have no complaints on the food and I have enough to drink" and "It's alright but nothing special, because they don't ask you." A relative told us, "It's good [name] eats really well." We spoke with the cook and found there were adequate stocks of food to fulfil the two week rolling menu and that food was nutritious and could provide a well-balanced diet. The cook knew people's food choices and any allergies. We saw people's food preferences were recorded in their care plans. The registered manager told us care staff sat with people and helped them fill these preference sheets in. We saw people were offered drinks throughout the day. However on the first day of our inspection we saw no snacks offered and there was no fresh fruit made available to people.

We spent a period of time observing the dining room to see how people were supported during meal times. We found there were two options available at meal times and people were shown the choices during meal times. There was no written or picture menu visible to people who lived at the home. We saw that food looked nutritious and most people who required support to help them eat, received it. People used adapted plates and cutlery if they needed to. Cold drinks were available to people on their tables.

One person was on a soft diet. The deputy manager explained the person had been referred to a speech and language therapist to obtain guidance about how to support them to maintain a healthy diet, due to their difficulty eating. They told us the person required support at every meal time. The person's nutritional care plan was not up to date, however the health professional's guidance was available on their records. When asked, care staff knew what support the person required. Care staff were able to explain how they monitored the person's weight on a regular basis to identify any changes to their wellbeing and how they would refer them to the GP if there were concerns. On the first day of our inspection we observed the provider helped care staff and supported the person to eat their lunch. Part way through the meal, the provider left the person to eat independently whilst they supported another person. The person struggled to eat independently and started to cough. On the second day of our visit, the same person was observed asleep during the tea time meal at 18.45pm, with their meal in front of them and no care staff to support them. When asked why the person was not receiving any support, care staff told us the carer who had been supporting them had been told to go on their break. This meant people were offered a choice of nutritious meals, however support for people with complex needs was not provided consistently to allow them to eat their meals safely.

Records showed that staff monitored people's health needs and referred them to other health professionals where appropriate. For example, the registered manager told us the GP had been contacted when they had concerns about people's nutrition or mobility. This meant people were supported to maintain their health and they received on-going health care.

Requires improvement

Is the service caring?

Our findings

People were positive in their comments about the staff. A relative told us, "When [name] sees their carer, they hug them. I see they're comfortable with staff." One person who lived in the home said, "Staff are caring." We observed care being delivered in the home. We saw care staff were friendly in their approach but communication with people was mostly when they offered support or were completing a care task. Some care staff were observed shouting to each other over people's heads about care tasks. Some care staff used language which was not appropriate, for example, "Toileting," when talking about supporting people with their personal needs. Some care staff did not always take the time to engage and communicate with people when they had the opportunity. For example, we used a short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met. On the first day of our inspection we observed two people in the upper lounge between 11.15am and 11.45am. There was no interaction between care staff and the people, despite care staff walking through the room past them. This meant people received limited stimulation and interaction, which they may have enjoyed.

People we spoke with who lived in the home told us visitors were welcome at any time. A relative told, "I visit regularly, there are no restrictions." This showed that people's relationships with their friends and families was promoted and not restricted.

People were supported to express their views about the care they received and were invited to meetings. Records from meetings showed that people were asked for their opinions, for example what they would like to eat. The registered manager told us they had used the information and provided new menu choices at tea times, such as cheese on toast. People had given their opinions on the care they received in a customer survey completed in August 2015. The registered manager told us care staff had supported people to complete the questionnaire and we saw the feedback was mainly positive.

A relative we spoke with told us they were involved in agreeing how their relation should be cared for and supported, because their relation was not able to communicate their preferences. They told us they were happy with the care their relation received. They told us they were invited to care review meetings which they found useful.

We asked people and their relatives if they felt staff treated people with dignity and respect. Two relatives told us, "They treat [name] with dignity and respect, although sometimes [name] has not got their own clothes on" and "Privacy and dignity is good, yes very much so, I have been here when they have changed [name]. They take [name] to the bathroom and are very kind." From our observations we found people were not always treated with dignity and respect. For example, at lunch time we observed people were supported to move from the lounge to the dining room to eat their meal. Some people spent one and a half hours waiting at the table until their lunch was served. There was little stimulation provided by care staff whilst they waited. We asked care staff why people had waited so long and one carer told us it was due to, "Toileting" people on the way. Another carer told us it was, "Hard work moving people around to the dining room."

We observed one person tell care staff at 12.30pm their top was wet because they had spilt a drink. The staff member told the person they would support them to get changed, however the person was not supported until 1.30pm. We observed another person at 7.40pm who was wet and in distress because they had soiled themselves. Care staff who were present in the communal room had been unaware until we brought the issue to their attention. A member of staff told us, "Oh yes, [name] will be first to bed." The person was not supported straightaway with their personal care needs.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.

Requires improvement

Is the service responsive?

Our findings

People told us they were happy with their care and support. Two relatives told us, "[Name] is happy here" and "I am generally happy with the care, they look after [name] well." We saw on people's care plans that some people had 'all about me' documents, which described their life history and information about their favourite hobbies or interests. This meant people were asked about their hobbies and interests, however we saw limited support for people to follow their chosen interests.

On the first day of our inspection we observed limited activities taking place in the home and consideration was not always given to people's preferences. We saw some people watched television. There was music playing on a stereo for part of the day and a hairdresser visited some people in the home. We did not observe care staff support people with their hobbies and interests on an individual basis. The registered manager told us, "We don't rota an 'extra body' on to do activities." The deputy manager told us, "We don't really have planned activities, it depends on people's moods." However we observed no evidence of staff determining people's moods and asking people what they would like to do. The registered manager told us that one person liked pets and they had arranged with the person's advocate for a 'pat dog' to visit them each week. We saw this was recorded on the person's care records. We saw photos on the walls of events which had taken place at the home, for example visiting animals and a tea dance. The registered manager told us there was a car available on Thursdays and they could take two people out at a time if they were mobile. They told us less mobile people were taken out locally and gave examples of three people who went out to the local community with staff or relatives. There was no evidence of trips outside the local community arranged for more than two people who were less mobile. This meant people's choices were limited or were not given a choice to be supported to pursue their hobbies and interests.

The registered manager told us that people were asked about their beliefs and cultural backgrounds as part of their care planning, however no one had expressed a specific interest. They told us one person used to be in the armed forces and so care staff supported them to attend a remembrance day service last year.

The care plans we looked at described people's needs and abilities and how staff should support people, however they did not adequately record people's preferences and this led to people receiving care which did not fully meet their needs. For example, we observed one person being supported by staff to go from the lounge to the dining room for their lunch. The person was supported to stand up three times before they went to the dining room. We observed the deputy manager supported the person to stand up initially. The person said, "I've got no shoes on," so the deputy manager supported them to sit back down and went to find their footwear. In the meantime, the provider encouraged the person to walk to the dining room. They supported the person to stand up and told them they had slipper socks on and they were not going outside. The person replied, "It's better with shoes." The provider then supported the person to sit back down and told them they would wait for their shoes. The deputy manager returned with the person's slippers and supported them to walk to the dining room. The registered manager told us this person, "Always likes to wear slippers and staff should have known this." Records showed the person's preferences for footwear were not recorded in their care plans. Staff who supported the person were not aware of their preferences and did not respect the person's choice.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014person centred care.

We saw people's care plans were regularly reviewed by a senior member of staff and people and their representatives were invited to annual care reviews. A relative told us they were invited to a review and said it was useful. The registered manager told us, "We sometimes sit with residents and explain care plans." We saw some people or their representatives had signed to confirm they agreed with the care and treatment received.

People told us they would talk to someone if they had a comment or complaint. A relative said, "I talk to the manager if I've got a concern." They told us they had raised an issue previously and the registered manager had dealt with it appropriately.

We saw the provider's complaints policy was accessible to people, because it was displayed in a communal area. Records showed there had been two verbal complaints recorded since our previous inspection in April 2015. We found the complaints had been responded to in

Requires improvement

Is the service responsive?

accordance with the provider's policy. We found people who lived in the home had been supported by staff to make comments and complaints about the service and these had been responded to by the registered manager. The registered manager told us they had begun recording all verbal comments people made, including compliments they received. We saw compliments on care received from people's relatives.

Inadequate

Is the service well-led?

Our findings

When we visited Roxburgh House on 14 April 2015 we found there was no effective system to assess, monitor and improve the quality and safety of the service for people living in the home. During this inspection we found continued concerns with the effectiveness of audits and the standard of the governance of the home.

Following our last comprehensive inspection, the registered manager sent us an action plan outlining how they would make improvements. They told us they had commenced a quality improvement plan to ensure the quality of the service.

We found systems and processes to assess, monitor and improve the quality and safety of services were not effective. We looked at the provider's system to monitor the quality of care they provided. We saw the registered manager and senior staff had completed a variety of checks as required by the provider. We looked at the infection control audits and found these checks were not effective. The audits had not identified many of the issues we had observed during our inspection. For example we found multiple issues in the kitchen on the first day of our visit, where dirt had built up over time and equipment was not clean. The infection control audit completed by the registered manager on 14 September 2015 which was the day prior to our inspection, confirmed that food was stored correctly, the area around the bin was clean and fixtures and fittings were clean. We asked the registered manager, the area manager and the provider why the audit had not identified the risks of contamination in the kitchen and we were told that they had not been aware of the issues. We found building rubble and a hole in the wall in the kitchen's dry store. We were told that this must have appeared when the new boiler was fitted in January 2015. This meant that one of the issues in the kitchen had been ongoing for nine months and had not been identified on the infection control audit. We saw the infection control audit identified there were no hand towels in some bedrooms. We found improvements had not been made as there continued to be no towels in some bedrooms on the first day of our inspection. We saw the registered manager had made an action plan of issues for the cleaner to address, they told us, "There are so many actions because don't have a cleaner at weekends." The provider did not have an effective system to prevent and control the risks of infection. Audits had not identified issues where there was a risk of infection and where issues were identified, improvements had not always been made. We found the registered manager and the provider had not acted in accordance with their action plan.

We looked at the medicine audit completed by the deputy manager on 14 September 2015, the day prior to our inspection and found that this was not effective. We found issues on the first day of our inspection which had not been identified on the audit. For example, the audit stated stock balances of medicines had been carried forward correctly and we saw they had not all been. The audit stated hand written entries had been double signed by staff, we saw they had not all been.

We saw there were arrangements in place for some medicine checks, however we found medicine errors were not always identified. We were shown a medication error report for July 2015 which identified one error which was not specific or detailed. There was no action plan or learning from the incident. No further medication errors were reported for August or September 2015, however we found one person had not received a dose of their prescribed medicine on 08 September 2015. The person's MAR sheet had been signed by staff to confirm it was administered, but the medicine remained in its dosage packet. The registered manager told us that medicine administration should be checked daily by a senior during staff handover and errors should be identified straight away. We observed staff handover on the first day of our inspection and did not observe the senior member of staff checking if medicines had been properly administered.

We found processes in place to determine staffing arrangements, were not effective. Staffing arrangements were not sufficient to enable staff to manage risks and meet people's needs safely. During our inspection we observed instances where staff were not available to meet people's needs. For example, one person waited for several hours to be supported to have a shave. The registered manager and the provider agreed they required more staff. We found the registered manager and the provider had not acted in accordance with their action plan.

There was no effective system to assess and manage risks to keep people safe. We observed instances where people were put at risk because risks to their health and safety were either not identified or were identified but information was not shared between staff to minimise the

Is the service well-led?

risks. For example some care staff were not aware one person had experienced a fall and did not monitor them to reduce further risks to their health and safety. These issues had not been identified by the provider or the registered manager.

The provider did not make sure the premises were properly maintained. For example a fire safety compliance check was carried out by the local authority on 3 September 2015. Records showed and we saw that eight deficiencies had been identified as requiring action by the provider to meet its legal responsibilities. The provider had no process in place to identify these issues.

Staff received training in all key areas of practice, however there was no evidence to confirm that training was effective. For example we found people were not always treated with compassion and their privacy and dignity was not always maintained, despite staff receiving training in these areas. The provider had not put processes in place to ensure staff's competency in these areas.

We found there were many aspects of the service that did not promote a positive culture which involved people in their care, and made sure they received care that was personalised and specific to their needs. Although care plans contained some personalised information about people, this information was not always used to support people in maintaining their preferences and wishes. People had limited opportunities to pursue their hobbies and interests.

The manager was aware of their responsibilities as a registered manager and had provided us with notifications about important events and incidents that occurred at the home. We found they notified most other relevant professionals about issues where appropriate, such as the local authority. However we found no records relating to reports of incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We discussed this with the registered manager and the provider, who had limited understanding of their legal responsibilities to notify incidents to the Health and safety Executive (HSE).

The provider and the area manager told us that they regularly visited the service to support the registered manager and to monitor the quality of the service provided. However it was of concern that they had not identified the quality and safety issues in relation to people's care.

The provider did not always follow best practice guidance. The local authority commissioners visited the service five times in the previous year and requested improvements be carried out. For example the local authority had requested in February 2015 that waste bins in the home be replaced with bins with foot operated lids, to reduce the risk of spread of infection. The provider told us they had not replaced the bins because it was not a legal requirement. We found many requested improvements had not carried out and the local authority had taken further action against the service as a consequence. The registered manager told us they would order bins as requested by the local authority, but told us they, "May not receive them," because the purchase may not be agreed by the provider. The service was checked by the local clinical commissioning group (CCG) for compliance in infection control in July 2015. A list of recommendations was made to make improvements in infection control. The CCG visited again in September 2015 and found few improvements had been made.

The provider had not ensured the management of the service was consistently effective so that people's needs were met. This has been identified through the last three inspections to the service where we found repeated non-compliance in meeting regulations. In July 2014, November 2014 and April 2015, we found continued concerns with the effectiveness of the provider's quality assurance system, where improvements were not made to ensure that people received safe care that met their needs. We found the registered manager and the provider had not acted in accordance with their action plan.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 good governance.

Everyone we spoke with told us they could speak with the registered manager at any time. A relative told us, "I have a good relationship with [registered manager], they are very approachable." Another relative told us, "I talk to the manager if I've got a concern." Staff we spoke with told us they felt supported by the registered manager. One member of care staff told us, "I have a supportive manager." Care staff told us there were regular staff meetings where

Inadequate

Is the service well-led?

they discussed, “All sorts of things, including cleaning rotas.” We found that staff meetings were infrequent. The last meeting took place in August 2015 and prior to that that it was in March 2015. There were other opportunities for staff to meet up and share ideas within the providers group. For example there a dementia champions meeting in August 2015, where a representative from each of the provider’s services met to share ideas about dementia care. Records showed the representative from Roxburgh House had commented, ‘Not much happened over the last few months as there has been so many issues with staffing.”

The registered manager told us they met regularly with other managers in the provider’s group. They told us they used this time to share ideas, evaluate information regarding any incidents which had happened at the home and discuss things to improve their service. The registered manager told us they found trends in falls. They said in May 2015 there had been 12 falls in the home. They discussed the information at the monthly meetings which helped identify a pattern relating to one person. The registered manager explained how action was taken to make improvements in the person’s care to prevent reoccurrence and reduce the risks to that person. They told us and records confirmed the number of falls in the home had reduced.

Records showed people were asked to provide feedback about the service through questionnaires. We saw three separate surveys had been sent out in August 2015, asking people who lived in the home, relatives and professionals for their opinions of the service. Records showed results of the surveys were positive. We saw compliments from relatives. The survey responses had not yet been fully analysed by the registered manager or shared with people because the responses had only recently been received. There were meetings for people who lived in the home held on an ‘ad hoc’ basis, the last one was in August 2015. People were asked for their opinions on the new dining room arrangements because meals were now eaten in the conservatory area rather than the lounge.

We found there had been some improvements to records and that care plans were easier to understand. One person’s care plan we looked at was not up to date, however we found care staff were aware of the change in the person’s needs. We found care records were sometimes not sufficiently detailed to support staff in delivering care in accordance with people’s preferences. We observed some staff were not aware of people’s preferences and therefore did not always respect people’s choices. We asked care staff if they read care plans and there was a mixed response. One care staff member told us, “There is not really enough time to read care plans.” The provider had not ensured that people’s preferences were always recorded and did not check care was delivered to meet people’s needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment did not always reflect people's preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because risks to people's health and safety were not always assessed and action was always taken to mitigate risks. The risk of preventing, detecting and controlling the spread of infection was not properly assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People were put at risk by premises which were not always clean and properly maintained.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not operate an effective system to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate risks relating to the health and safety of service users.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs.

This section is primarily information for the provider

Enforcement actions

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