Rymacare Limited

Roberts Lodge

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Roberts Lodge is a residential care home which can provide care and accommodation to up to four people. At the time of the inspection four people were living at the service. Roberts Lodge provides support to adults who have a range of health and social care needs including learning disabilities, autism spectrum disorder and/or physical disabilities.

Roberts Lodge is a domestic style property and people's accommodation and living areas were spread across three floors. People had their own bedrooms and ensuite and access to a range of communal areas including a lounge, dining room and secure garden area.

The service has been developed and designed taking into account the principles and values that underpin Registering the Right Support and other best practice guidance. This guidance ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. The guidance supports people using the service to receive planned and co-ordinated person-centred support that is appropriate and inclusive for them. The service was a small home which fits with the local domestic style properties. It was registered for the support of up to four people, in line with best practice guidance. There were deliberately no identifying signs, industrial bins or anything outside to indicate it was a care home.

People's experience of using this service and what we found
There were safeguarding procedures in place, however we found that the provider did not always effectively follow their policy to ensure they met their legal requirements. We found risks to people were not always effectively identified or appropriately assessed. We found environmental risks such as legionella bacteria and fire safety measures were not always appropriately managed to ensure people's safety. Staff practices supported people to manage the risk of acquiring an infection. We spoke with relatives who provided positive feedback on the care their loved one's received. People were supported to receive their medicines safely and had appropriate levels of staff support to meet their needs.

The service did not always operate good governance. Systems in place to review the quality of people's care and ensure records were complete and accurate were not always effective. Audits were not always robust and did not identify the concerns we found at this inspection. The provider was unable to demonstrate evidence of effective oversight of the service for the duration of the service registration. We received professional feedback that leadership roles and responsibilities were not always clear.

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

Rating at last inspection
This service was registered with us on 18/10/2019 and this is the first inspection.

Why we inspected
We received concerns in relation to the providers ability to implement and adhere to national guidance in response to the COVID-19 pandemic. These were raised both by local health commissioners and through our on-going engagement with the service. The concerns were that staff were not wearing the appropriate personal protective equipment (PPE) and infection risks to people, specifically around COVID-19, had not been robustly assessed or managed. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. As this service has not received a rating in any of the other key questions, we have not provided an overall rating for the service. However, each of the key questions we looked at has had a rating calculated based on the evidence we reviewed.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to people's safe care and treatment, incidents of failing to escalate information relating to safeguarding people from abuse and a failure to ensure good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Roberts Lodge

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors and one assistant inspector. Two inspectors visited the home. Another inspector and assistant inspector looked at information the provider sent electronically. This was to ensure we only spent the time on-site that was needed.

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

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we held about the service since it registered. We sought feedback from commissioners of the service. We used all of this information to plan our inspection.

During the inspection
We attended the service on the first day of the inspection activity where we sought information from the registered manager. We reviewed practices and records relating to aspects of people's care including medicines, infection control and staffing levels. As a result of people's complex care and communication needs, we were unable to gain people's view of their experience of the care provided, therefore we spent time observing how staff supported and engaged with some people who use the service. We also spoke with a visiting relative to gain their feedback.

After the inspection
We continued to seek clarification from the provider to validate evidence found. After the on-site visit we requested a range of documents from the provider which included people's care records and audit tools the provider used to maintain oversight of the quality of peoples care and the service provided. We spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider, four members of staff and two relatives. We also sought feedback from professionals who worked with people at the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding systems and processes had not been consistently followed. For example, we found evidence on two occasions where members of staff had raised safeguarding concerns with the leadership team which had not been appropriately shared with the local authority. The local authority hold the legal responsibility for ensuring people are safeguarded from abuse and neglect and sharing this information is a legal requirement. We raised this with the provider who could not demonstrate that the necessary actions been taken in line with their safeguarding policy. We told the provider to take immediate action to address this which included sharing information with the relevant local authority.

The failure to follow appropriate safeguarding protocols and legal requirements placed people at risk of avoidable harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received training to support their understanding of safeguarding adults. Staff we spoke with knew how to raise a concern and told us they would report any concerns to senior management.
- The provider employed an external quality control manager. This encouraged staff to escalate any concerns they had outside of their organisation to seek advice and guidance.
- We spoke with relatives who told us they felt staff worked well with their loved ones to keep them safe.

Assessing risk, safety monitoring and management

- Fire risks were not always effectively managed. A fire risk assessment was in place and staff had received fire training. However, we observed a tumble dryer was placed in a cupboard underneath the staircase and the registered manager confirmed that it was used. Government guidance on fire safety in residential settings states fire ignition risks should not be located on any corridor or stairway that will be used as an escape route. The home is on three levels and there was only one staircase to access the ground floor escape routes. We raised our concerns about the fire risks associated with tumble dryers and the positioning under the stairs. The provider could not demonstrate that the risk of the equipment had been considered.
- People's personal emergency evacuation plans were not accurate. Information stated there were 60 minute fire doors, which are designed to withstand fire for this time. Staff were instructed to follow the provider's stay put policy in the event that people refused to leave. We discussed fire practices with the provider who confirmed this information was not accurate and fire doors actually provided 30 minute fire protection. They took immediate action to correct this for people's safety.
- Required weekly testing of the fire alarm system had not been consistently carried out. We reviewed records which evidenced that weekly checks had only been carried out once a month in July and August

2020.
● The provider had a risk assessment dated, 21 November 2019, regarding Legionella and Legionnaires' Disease. Legionnaires' disease is a potentially fatal form of pneumonia caused by Legionella bacteria which is commonly found in water. We noted the risk assessment identified a number of actions which were needed to reduce the risk of Legionella being present and five were prioritised as high risk and needing to be completed within one to three months. This included the need to increase the temperature of water at a certain point in the system and to remove a 'dead end' piece of pipe, where bacteria could be present. The provider was aware that some of the actions were required to be completed by February 2020. The provider could not demonstrate that any works had been scheduled. Poor management and oversight of the water system to address these actions left people exposed to the risks associated with legionella.
●Systems used to assess risk were not effective and did not identify and consider all known risks to people. For example, where a person was described as having unpredictable behaviour towards staff, there were no risk management plans in place to assess the risk to the person, staff or others at the service. We also found most risk assessments for people were often vague, lacking in required detail and had limited guidance on control measures staff should follow.

We found no evidence that people had been harmed. However, the failure to effectively assess the health and safety of risk to people and ensure all reasonably practicable steps have been taken to mitigate risk placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. For example, the registered manager removed the tumble dryer from the service during the on-site visit. The provider also told us they planned to schedule works to address the legionaries action plan.

Staffing and recruitment
● People's needs were met by sufficient numbers of suitable staff. The service had permanent staff, as well as a bank of staff who filled any gaps in the rota. Where the service had needed to use agency staff, records confirmed the same two staff had worked to ensure consistency.
● There was a safe recruitment pathway for new employees. This included disclosure and barring service (DBS) checks for new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working in health and social care.

Using medicines safely
● People received their medicines as prescribed and there were care plans in place where people were prescribed medicines 'when required'.
● Medicines were stored safely and securely, and records were completed appropriately.
● Staff were trained in administering medicines and their competency was assessed by the registered manager.

Preventing and controlling infection
● The provider had processes in place to reduce the risk of the spread of infection.
● There were reasonable steps in place to protect people from the risk of acquiring an infection. This included the completion of cleaning schedules and audits.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider had sought to access testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were not completely assured that the provider's infection prevention and control policy was up to date. We received feedback from health commissioners that the provider's policy could be strengthened in areas and signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● The provider used action plans to implement improvements. For example, we reviewed manager meeting minutes from August 2020 which highlighted areas of practice the service was focusing on. This included updating the format of people's support plans to be more person centred. Feedback from the meeting was compiled on an action plan which included what action was required, by whom and target dates for meeting the recommendations. We saw evidence that targets set had been achieved.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had some quality assurance processes in place to monitor and review the overall delivery of people's care and the service provided, however these were not always effective.
- The provider could not demonstrate that there had been effective monitoring and review of the service delivery since their registration. We requested evidence of audits completed between the month of January 2020 and April 2020 which they could not provide. Therefore, we could not be assured they had provided a consistent level of service. The provider told us this was being addressed, and we saw evidence of audits implemented from this date.
- Audits of people's care files were not robust in identifying or driving improvements in line with our findings. Systems in place failed to ensure all care records reflected effective assessment and management of potential risks to people, or to ensure staff had access to appropriate levels of detail to recognise and respond to people's individual needs. For example, people's behaviour management plans did not include all required information on the use of physical intervention, such as what, how and when physical interventions should be used.
- We could not be assured of the quality or consistency of audits completed. For example, we reviewed medicines audits completed in July 2020 which did not identify any areas for improvement, however the same audit tool completed in August 2020 identified a number of areas that required action. This included identifying consent for administering medicines had not been recorded in people's records and required immediate action.
- Governance of staff records was not always effective. For example, during the on-site inspection the registered manager was unable to provided assurances on the safe recruitment of a staff member as required documents were not available. The provider was later able to demonstrate safe recruitment had been completed. We also found records used to monitor staff skill and training information was not up to date. The provider was responsive to our feedback and addressed this.
- We reviewed records relating to the services COVID-19 response and risk management. We found information was not always clearly presented and did not include all required risk reduction measures such as consideration of people and staff who may be more at risk of acquiring the virus and what action would be taken.

The provider's governance systems were not always effective and failed to consistently assess, monitor and drive improvement in service delivery and ensure all records relating to people's care were up to date and contemporaneous. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● Providers are legally required to tell the care quality commission certain information relating to accidents, incidents or events that occur at the service. This is achieved by completing a statutory notification. During the inspection we identified the provider had failed to notify us where concerns had been raised regarding the quality of care provided.

Failing to notify the care quality commission of all required information is a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Following our feedback, the provider took immediate actions to review systems in place for monitoring their compliance to the regulations which included implementing additional auditing checks to be completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Most staff told us they felt comfortable raising concerns with the management team and felt their feedback was taken on board.
● Staff were encouraged to share their ideas and views on the service and the care people received through regular supervision, team meetings and key worker responsibilities. This included reviewing how they felt people had engaged in activities and what new opportunities people may like to try.
● The registered manager told us the culture of the service and relationships between staff had improved in recent months. To support this and encourage good practice and role modelling the provider had recently implemented an award scheme through staff member of the month.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider has a policy in place which set out their duty of candour requirements. The duty of candour sets out actions that the registered manager should follow when things go wrong, including making an apology and being open and transparent.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Most relatives told us they had good communication with the home. Care records demonstrated staff regularly shared relevant information where this was appropriate.
● People were supported to be involved in planning their care. For example, the provider had recently adopted SMART goal setting within people's care plans to enable people with support of staff to set personal targets they would like to achieve. This included aspirations to become independent in tasks and access community services.
● The provider was in the process of implementing a survey to seek feedback from relatives and visiting professionals.

Continuous learning and improving care
● During the inspection we identified a number of areas that required improvement. The registered manager and nominated individual were responsive to our feedback. The registered manager told us they and staff were committed to "getting things right" and improving outcomes for people.
● We received feedback from relatives that staff were continually learning about their loved one and their loved ones needs in order to improve outcomes for people. For example, one relative said, "They seem to be able to manage [loved ones needs] and are learning how to better managed."

Working in partnership with others

● We received feedback from professionals that leaders of the service generally engaged well. However, some professionals told us there was confusion between the roles of the management team which lead to inconsistent approaches and communication.

● Peoples care records demonstrated staff and management sought appropriate input from professionals to meet people's needs. This included making relevant referrals to other specialists such as behavioural support professionals, speech and language therapists and other health professionals.

● The service used different approaches to support important people to be involved discussions relating to their loved ones care. A relative told us, "We have had [online] meetings with social services and psychiatry and the managers were there too."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. How the regulation was not being met: The failure to notify the Commission without delay of incidents specified in paragraph (2) which occurred whilst services were being provided in the carrying on of a regulated activity. Regulation 18(1)(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The failure to effectively assess all the health and safety risks to people and ensure all reasonably practicable steps have been taken to mitigate risks. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:
The provider failed to effectively investigate and take all required action to meet their legal requirement to safeguard people from the risk of abuse and neglect. This included a failure to recognise where information should have been shared with the local authority.

Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The failure to maintain accurate, complete and contemporaneous records and operate effective governance processes to ensure compliance with regulations. Regulation 17(1)(2)(a)(b)(c)