Discovery Care Limited

Roxburgh House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Roxburgh House is a residential care home providing personal to 14 people with a variety of needs. People's needs include, physical disabilities, dementia, learning disability or long term mental health conditions. The service can support up to 22 people in one adapted building.

People's experience of using this service and what we found
There was a lack of leadership at the service and the quality of care people received had not improved. The provider and staff did not share a sense of direction or vision and values. Robust plans had not been put in place to drive change and the lack of progress had not been recognised. Checks and audits were not robust and had not identified shortfalls we found.

People's views and opinions had not been used to improve the service. Some people had raised concerns but these had not been addressed. Others did not raise concerns as they were not confident, they would be addressed.

People continued to be at risk from the spread of infection, including Covid 19. The vacancy for a cleaner had not been filled and the post had not been covered.

Staff were not deployed to a sufficient level to meet people's needs. People had to wait assistance at times. Care staff were required to completed domestic duties and this took them away from people. Staff had not completed practical refresher training in key skills such as moving and handling. Medicines were not consistently well managed and recorded.

People told us they were bored at times. There was no programme of activities or occupation and people spent their time doing nothing. People had asked to go out but had not been supported to do this.

Preadmission assessments remained inadequate and care had not been planned with people when they began to use the service. Risks had not been identified for everyone and action had not been planned to mitigate risks.

Staff were recruited safely.

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

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 25 January 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to confirm the provider was now met legal requirements because we were not assured they had acted to improve the service. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roxburgh House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to low staffing levels and staff training, risk management, medicines, lack of oversight by the provider and registered manager, not acting of feedback, inaccurate records and failure to notify CQC of significant events at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Roxburgh House

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was completed by an Inspector and an Assistant Inspector.

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

The service 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 24 hours' notice of the inspection. This was to check if anyone had suspected or confirmed COVID 19 and arrange for information to be sent to us.

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 had received about the service since

the last inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with five staff, including the registered manager, the cleaner and care staff.

We reviewed two people's care records, records relating to building safety, checks and audits and two staff files in relation to recruitment and induction.

After the inspection
We spoke with three people's relatives and six staff. We also spoke with a member of the clinical commission team care homes support team. We continued to seek clarification from the registered manager to validate evidence found. We looked at staffing rotas, training records and minutes of meetings.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection sufficient numbers of staff had not been deployed to ensure people's needs were always met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider and registered manager continued to be in breach of regulation 18.

● People continued to be at risk because there were not enough staff to keep them safe. Staff deployment was not planned around people's needs. The registered manager used a system to decide how many care hours were required each day but not when they were needed. Such as in the morning when everyone wanted to get up and have breakfast. Care staff were also required to complete household tasks including cleaning, laundry, and serving meals. This was not included in the calculation and took them away from supporting people.
● Two care staff were deployed on each shift. Some people required two staff to help them with aspects of their care. When staff were supporting one person, no staff were available to support the other 13 people. Staff told us they either left the person they were helping or other people had to wait. This placed people at risk. People and their relatives commented that staff were "hard pushed" and appeared "stressed out" at times. One staff member told us people were "missing out on things", as staff had no time to spend with them. Another staff member told us, "I'm not a carer, I don't have the time to care"
● The number of staff employed was low and staff worked long hours each week. Staff had not been allowed to take leave during the pandemic. Three night staff covered 14 shifts per week. Night staff worked up to 60 hours a week and some told us they were tired. Cover had not been planned for a member of care staff who was working their notice. The registered manager told us they had been unable to fill a vacancy for a cleaner since our inspection in November 2019. They had not covered the vacancy and plans were not in place to cover the existing cleaner's leave.
● Staff had not completed practical training in how to move people safely. Some staff told us they had not completed any face to face training, other staff had not completed refresher training. The registered manager told us they had not arranged face to face training in any subject since the Covid pandemic began. We observed two staff support one person to move safely. However, staff had not been able to support another person to get up when they had fallen because they did not know how to do this safely. There remained a risk people would not be moved safely.

The provider and registered manager had failed to deploy sufficient staff with the skills they needed to keep

people safe. This left people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to follow safe recruitment processes, to ensure staff were of good character. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● New staff had been recruited safely. Checks on staff's character and previous employment, including dates of employment and reasons for any gaps in employment, had been obtained. Criminal record checks with the Disclosure and Barring Service had been completed.

Assessing risk, safety monitoring and management
At our last inspection a process was not in operation to record the assessment of people's needs before they began using the service. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider and registered manager continued to be in breach of regulation 9.

● Following our last inspection, the registered manager told us they had implemented a comprehensive preadmission assessment process. This process had not been completed before a person moved into use the service. Detailed information about the person's needs had not been obtained. For example, the assessment noted the person needed support from staff to complete day to day tasks such as washing and dressing. No information was included about what the person was able to do and the support they needed. We would expect detailed information to gathered so the registered manager can assure themselves staff could meet the person's needs.

The registered persons had failed to operate an effective process to assess people's needs before they began to use the service. This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection people were not protected from the risk of fire. Staff had not followed guidance about how to move people safely and the risk of people losing weight had not been identified. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider and registered manager continued to be in breach of regulation 12.

● Some issues related to fire safety had been addressed, however risks to people remained. One person did not have a personal emergency evacuation plan in place. Staff told us they were not able to evacuate other people from the basement of the building. Some staff had not practiced using evacuation equipment and others told us they were not confident to use equipment following training. Staff's first aid training had expired and the registered manager had not arranged for it to be renewed.
● Risks to one person had not been assessed and guidance had not been provided to staff about how to support the person to remain safe. The person had poor mobility and used mobility aids. This increased

their risk of falling. A falls risk assessment had not been completed and detailed guidance had not been provided to staff about how to support the person to remain safe.
● Information about areas of people's care was not clear and staff did not support them consistently. One person had behaviours which challenged staff on occasions. Staff gave us examples of times the person had shouted or refused support. They each described responding in a different way. The registered manager told us the person did not have behaviours which challenged and they did not know why they had included this in their care plan.
● One person's care plan contained contradictory information about their hearing and the use of aids. Their care plan said their hearing was good, their assessment said they used a hearing aid in their one ear. Information from the local authority stated their wore aids in both ears. The person was unable to hear us when we tried to speak with them during the inspection.

The provider and registered manager had failed to protect people from the risk of fire. Risks related to one person's care had not been assessed and care had not been planned to keep them safe. This placed people at risk. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the building and equipment had not been maintained and kept clean. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider and registered manager continued to be in breach of regulation 12.

● People continued to be at risk from the spread of infection. Sinks, baths and toilets were still stained with limescale and products had not been purchased to remove it. Limescale gives germs a place to multiply. A rusty shower chair had not been replaced and continued to be in daily use. This made it impossible to keep these areas clean and hygienic.
● Cleaning schedules had been implemented and showed cleaning of high traffic areas was not completed daily. For example, one 'bathroom/toilet' cleaning checklist was in place. This did not detail when each toilet and bathroom had been cleaned. This made it impossible to audit the records to ensure each area had been cleaned regularly.
● The provider had put a Covid 19 policy and risk assessment in place. However, these did not include adequate measures to prevent the spread of Covid 19. Checks had not been completed to ensure measures described in the policy and risk assessment were completed. For example, the registered manager told us door handles and other high touch points were cleaned early in the morning. They were not continually cleaned throughout the day as required by the policy. People and staff moved around the building constantly touching door handles and handrails. This increased the risk of the spread of infection.
● At times staff covered vacant shifts at the provider's other service. Staff from the provider's other service also covered vacant shifts at Roxburgh House. National guidance states the movement of staff between services should be avoided during the pandemic to reduce the risk of the spread of Covid 19.

The provider and registered manager had failed to ensure the building and equipment were maintained and kept clean. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our last inspection the broken laminate worksurface in the laundry room had been replaced. The

kitchen cupboard had been repaired and no longer smelt of damp. Vacant bedrooms were being refurbished and some communal areas have been redecorated. Staff had completed infection control training.

Using medicines safely
At our last inspection we found detailed records had not been kept about some medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had not been made at this inspection and the provider and registered manager continued to be in breach of regulation 12.

● Records in relation to some medicines were incorrect. Some medicines were recorded in a special book. Staff had not kept a separate record of each medicine under people's names as required. There was a risk people would be given the wrong medicine if more than one medicine was recorded in the book.
● Two people were prescribed a medicine which is usually administered 'when required'. The registered manager and staff knew the medicine was usually given when required. Information on the prescribing label was unclear about when the medicine should be taken. Staff had not sought clarification from people's GPs to ensure it was taken safely. Staff supported people to take the medicine four times each day. There was a risk that by taking the medicine frequently any change in the people's health would not be identified.
● People were not always supported to take their medicines in a consistent way. The registered manager told us one person took a medicine without support. Staff told us they administered the person's medicine for them. Guidance was not in place for staff to follow about how to support the person consistently to take their medicines.

The provider and registered manager had not ensured staff followed safe and consistent processes when managing medicines. This placed people at risk. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe systems were in operation to order, receive, store, and dispose of people's medicines. Since our last inspection guidance around when required medicines had been improved to include the maximum dose in a 24 hour period and when they are required.

Learning lessons when things go wrong
At our last inspection we found a process was not in operation to review accidents and incidents to look for patterns and trends. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● The registered manager had begun to use a process to monitor accidents and incidents to look for patterns and trends. This included accident reviews looking at when and where accidents occurred. No patterns or trends had been identified. Accidents at the service continued to be rare.

Systems and processes to safeguard people from the risk of abuse
● Staff had completed training and knew about different types of abuse. They were comfortable to report any concerns to the registered manager and provider. Staff knew how to blow the whistle outside of the

service if they needed to.

● The registered manager had discussed any concerns about people's safety with the local authority safeguarding team. When necessary action had been taken to prevent incidents occurring again.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The lack of strong leadership and shared direction had impacted on the quality of people's care. Following our last inspection, the provider told us they would recruit a deputy manager to support the registered manager. They had not done this. The registered manager continued to be responsible for all management tasks and complete care tasks. Previously the registered manager told us they did not have time to fully complete their role and this had not changed. The provider had failed to address this.
- The provider and registered manager were out of touch with what was happening at the service. They had not recognised the pressure low staffing numbers and long hours placed on staff. The registered manager was unaware people went for long periods without interaction with staff. Shortfalls at the service were blamed on the Covid 19 pandemic rather than failures by the leadership team.
- The culture at the service had not been kept under review. The provider and registered manager had not developed a culture of respect and inclusion for everyone. For example, in care plans the registered manager had described one person as 'snappish' and 'having a swearing fit'. We discussed inclusion with the registered manager. They did not recognise people needed support tailored to their needs to enable them to be involved and valued.
- Staff were not able to describe the vision and values of the service. One staff member told us the aim was, "To keep people happy and safe". People's care had not been planned with them to support them to develop and maintain their independence.

Continuous learning and improving care

At our last inspection we found a robust quality assurance process was not in operation. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider and registered manager continued to be in breach of regulation 17.

- The provider and registered manager continued not to have a good overview of the service. We required an action plan from the provider following our last inspection. The provider reviewed this in April 2020 and one high risk area remained outstanding. No further reviews had taken place and the high risk area had not been addressed. Other actions we were told had been completed, had not been. For example, a new keycode lock had not been fitted to a fire escape door. At our last inspection the registered manager

planned to change the dining room into a games room. Work on this project had not begun.
● An action plan had been put in place following people's feedback. Suggestions people had made had not been acted on in the timescales on the plan. For example, one person had suggested a quiet area for reflection. The timescale to achieve this was August 2020. However, this had not been achieved and the only quiet place available to people was their bedroom.
● Reviews of people's care plans and risk assessments were not effective. For example, staff had signed to confirm one person's emergency and evacuation plan had been reviewed in August and September 2020. The person did not have an evacuation plan in place.
● Checks and audits completed by the registered manager were not effective and had not identified the shortfalls we found. Checks were not always robust. For example, the medicines audit did not cover medicines which require additional storage and records. The infection control audit did not include additional measures to protect people from Covid 19. Some areas of the service, such as people's care plans and risk assessments had not been reviewed.
● The provider had not identified shortfalls at the service. They checked the registered managers audits but did not complete any checks of their own . The provider visited the service weekly but did not encourage open and honest conversations with people and staff about any concerns they had. People told us they had raised concerns with the provider but these had not been acted on. Staff told us they contacted the provider about emergencies in the registered managers absence. They did not have the opportunity to discuss any issues they had about the day to day running of the service.

The provider and registered manager had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The views of people, their relatives and staff were gathered but not acted on to improve the service. At residents' meetings in March and June 2020 people had suggested having a weekly barbeque in the garden. One barbeque had been held but no more had been arranged. In a survey people had asked to go out more. Again, this had not been acted on and people had not gone out since before the Covid 19 restrictions began in March 2020.
● People were not confident concerns they raised with the provider and registered manager would be acted on. One person was unable to read as the charger for their e-reader was missing. They had not told the registered manager because, "She's so busy, I don't like to complain". Two people told us they were unable to watch television in their bedrooms as the reception was very poor. This made them very frustrated and angry. They had informed the provider and raised it at the residents meeting but the issue had not been resolved. This was despite the provider telling us they would address this at our last inspection.
● People were part of a residents committee. The committee had introduced some new activities in February and March 2020 but these had not been sustained.
● We observed most people continued to spend their time watching television or doing nothing. One person told us watching television was "boring" and "I don't like it". The registered manager told us people were responsible for organising the activities. However, activities had not happened regularly. The registered manager blamed the pandemic, saying, "There have been problems since Covid". They had not taken action to make sure people were supported to take part in activities they enjoyed. This was especially important as people were not able to go out and many relied on staff to facilitate activities for them.

The provider and registered manager had failed to act on feedback from people and their relatives to

continually evaluate and improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. During our inspection the registered manager told us they had been absent from the service for at least 6 weeks. The provider had not informed us of the registered manager's absence or who they had appointed to lead in the registered managers absence.

● The registered manager had notified us of events that happened at the service. However, we were not always told promptly. There had been a delay of approximately one month in us being notified that a person had died.

The provider had failed to notify the Care Quality Commission when the registered manager was absent for more than 28 days. This was a breach of regulation 14 (Notice of absence) of the Care Quality Commission (Registration) Regulations 2009

The provider and registered manager had failed to notify the Care Quality Commission, without delay, of the death of a service user. This was a breach of regulation 16 (Notification of death of a service user) of the Care Quality Commission (Registration) Regulations 2009

At our last inspection we found the provider had not maintained accurate and complete records in relation to the service and people's care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records in relation to the running of the service were inaccurate. For example, a staff rota given to us by the registered manager showed a member of care completing two cleaning shifts. The staff member had resigned and worked their notice. They no longer worked at the service.

The provider and registered manager had not maintained accurate and complete records in relation to the service and people's care. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had not kept up to date with developments in the care sector. They had not completed any additional training to develop their leadership skills since our last inspection. The registered manager did not receive supervision to discuss any challenges in their role. They had not had the opportunity to explore any support, advice or guidance they needed to make the required improvements at the service. The provider did not have the skills to support them.

● The registered manager had not challenged the provider about their failure to support improvements. For example, when we discussed the lack of action to deploy cleaning staff, the registered manager told us, "I don't hold the purse strings". They had not considered the impact of not acting on people and staff or demonstrated the risks of not deploying cleaning staff every day.

Working in partnership with others

● The support and resources offered by outside agencies, such as Skills for Care, had not been used to move the service forward. Skills for Care support providers and registered managers to provide a good quality

service by getting the best from their staff.

● The registered manager shared information with health care professionals to ensure people's health care needs were met. They engaged in weekly calls with staff from the local clinical commissioning group and raised any concerns they had around people's health.