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

About the service
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
People were not always safe at Roxburgh House. Some people told us they were scared at times. Allegations of abuse and incidents between people had not been shared with the local authority safeguarding team so they could be investigated.

There was a continued lack of effective leadership and oversight by the provider and this had led to failures throughout the service. The provider had failed to make the required improvements following the last inspection in September 2020 and breaches of regulation continued. Checks and audits completed had not identified the shortfalls we found at the service. People were not valued and were not at the centre day to day life at the service. They were not encouraged or supported to maintain and develop their independence. People's views and opinions were not listened to.

The provider had not developed an open culture and there was a lack of trust and respect between the provider and staff. Most longstanding staff members had left. A blame culture had developed between the provider and staff and staff did not work as a team to support people.

Risks associated with diabetes, epilepsy, choking, catheter care and behaviours which challenge had not been robustly assessed and action had not been taken to reduce risks to keep people safe. People continued not to be protected from the risks in the event of a fire. Accidents and incidents were not reviewed to identify any patterns or trends and reduce the risk of them reoccurring.

Medicines were not managed safely. People did not always receive the medicines they were prescribed by their doctor and one prescribed medicine was shared between four people. There continued to be no guidance available for staff about people's 'when required' medicines.

Improvements made to staff recruitment process had not been maintained. People were not protected from the risks of staff who did not have the skills to fulfil their role or were not of good character. Staffing levels were not consistent to ensure people received the care and support they needed. Staff continued to work long hours.

The cleanliness of the building had improved but people continued to be at risk from the spread of infection. Laundry and rubbish were not managed or stored safely. Government COVID-19 guidance had not always been followed. The new manager had not begun to develop their relationship with other professionals involved with the service

Records at the service were inaccurate or incomplete. Medicines records contained gaps in the administration of medicines and some important records could not be found such as medicines sent for destruction. Staff rotas did not reflect who had worked at the service. Some recruitment records were not easily accessible. Personal information about people was not held securely.

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 inadequate (published 14 November 2020) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the leadership and culture of the service, maintenance of the building, the registered manager leaving and staff not being able to meet people's needs. A decision was made for us to inspect and examine those risks and follow up on action we told the provider to take at the last inspection. 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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

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 people's safety, medicines management, staff recruitment, staff deployment, responding to allegations of abuse, effective checks and audits, records and seeking and acting of feedback from people, their relatives and staff at this inspection.

We took urgent enforcement action against the provider and applied conditions to their registration.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 three inspectors.

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 manager registered with the Care Quality Commission was no longer working at the service. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, the fire and rescue service and other professionals who work with the service. We also spoke with whistle blowers about their experiences of the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with ten members of staff including the provider, nominated individual, manager, area manager and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits, fire safety and maintenance records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance and maintenance records and the provider's insurance documents. We spoke with three relatives about their experience of the care provided.

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last two inspections the provider had failed to protect people from the risk of fire and assess risks relating to the health, safety and welfare of people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No improvement had been made at this inspection and the provider was still in breach of regulation 12

● Some people living at Roxburgh House were at risk of serious harm. One person was not supported to live well with diabetes. The person was not offered a low sugar diet they required. Staff took the person's blood sugar levels twice a day. Guidance had not been provided to staff about safe blood sugar levels or the action to take if they were too high. The person's blood sugar levels were consistently high. Staff had not identified this and had not contacted the person's GP or diabetic nurse for advice. Following our inspection, the provider sent us an updated care plan and risk assessment. This did not assure us risks to people were managed as there continued to be a lack of guidance for staff to follow about how to support the person remain safe or identify their changing needs.
● Care had not been consistently planned to support people with epilepsy and protect them from harm. Brief guidance had been provided to staff about one person's epilepsy. However, details of what a seizure may look like for them, had not been provided and staff could not tell us about the person's seizures. Staff did not know what action to take if the person had a seizure. Following our inspection, the provider sent us an updated care plan and risk assessment. This did not assure us risks to people were managed, as guidance had not been provided to staff about what a seizure looked like for the person or how to respond if they had more than one seizure.
● Some people used catheters to help them pass urine. Their catheter care had not been planned to ensure any concerns were identified quickly and reported to health care professionals. One person's catheter regularly blocked and had to be replaced. No guidance had been provided to staff about how to care for the catheter or recognise if it was blocked. We were not assured staff knew how to identify if the catheter was blocked as most staff who knew they person had left. Records of what the person drank and fluid they passed were not consistently maintained. They were not reviewed daily to check the person had drank enough and their catheter was draining well. Following our inspection, the provider sent us an updated care plan and risk assessment. This did not assure us risks to people were managed, as guidance had not been provided to staff about how identify the catheter was blocked or the minimum fluid intake and output for the person each day.
● People were not protected from the risk of choking. Some people's drinks were thickened to reduce the risk of them choking. Guidance had not been provided to staff about the consistency of drinks each person required, and this varied from person to person. Staff told us one person required foods to be pureed to

reduce the risk of them choking. The person's risk of choking had not been assessed by health care professionals since 2018 and they had not advised the person to have a pureed diet. No further referrals had been made to health care professionals when the person's risk of choking changed. The person's midday meal looked unappetising and the person told us they did not like all their foods pureed together. On occasions they chose not to eat pureed foods. Guidance had not been provided to staff about how to support the person to make informed choices about their food or the action to take to reduce the risk of them choking. No additional checks were completed on the person and no guidance had been provided to staff about how to respond if the person choked. Following our inspection, the provider sent us an updated care plan and risk assessment. This did not assure us risks to people were managed, as guidance had not been provided to staff about the consistency of the fluids the person required. The consistency of food descripted did not reflect how their meals were prepared during the inspection.

● Some people had behaviours which challenged staff or injured themselves. One person frequently injured themselves. Guidance had not been provided to staff about the action they needed to take to reduce the risk to the person and they continued to harm themselves. Guidance had not been requested from health care professionals to manage this risk. Staff told us they were not able to meet the person's needs and were concerned for their own safety and the safety of others. Following our inspection, the provider sent us an updated care plan and risk assessment. This did not assure us risks to people were managed, as they have stated there was no cause to the behaviour. All behaviour which challenges has a cause. The provider had also failed to describe the types of behaviour the person may have,

● People continued to be at risk in the event of a fire. Action had not been taken since our last inspection to support people to safely evacuate from the basement of the building. Fire risks were not managed, and we observed fire doors being propped open. Combustible items were not stored safely. We shared our concerns with Kent Fire and Rescue Service who had already required the provider to make improvements. Checks on some areas of fire safety had been completed.

● The building had not been maintained to a good standard. Some maintenance issues had not been addressed in a timely manner. The shower room was reported to be out of action in 15 February 2021 and remained out of action when we inspected. External contractors who had visited during the pandemic, had highlighted areas of concern and made recommendations regarding the lift, fire alarm and electrical installations which the provider had not addressed. The provider was unable to demonstrate legionella tests had been completed.

The provider had failed to protect people from risks related to fire and the environment. Risks related diabetes, catheters, choking, epilepsy and behaviour which challenged had not been assessed and care had not been planned to keep people 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.

Using medicines safely

At our last two inspections the provider had failed to ensure staff followed safe and consistent processes when managing medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's medicines were not always managed safely. In February 2021 the provider told us they had put new guidance in place for 'when required' medicines, such as pain relief. However, we found guidance was not in place for staff to support them give the medicines safely. Staff had not consistently recorded the reasons medicines had been administered, to inform medicines reviews and ensure they were given safely and consistently. This was identified in the providers January 2021 medicines audit, but robust action had not been taken to ensure the administration of when required medicines was accurately recorded.

● People did not always receive their medicine as prescribed. One person was prescribed medicine to be administered three times each day. Medicines administration records (MAR) showed the person had received one dose a day. Staff were not able to tell us what the medicine was for or why it had not been given as prescribed. This left the person at risk of harm, pain and discomfort. A stock of Vitamin D drops provided by the government to support people's general health and keep their bones and muscles healthy during the COVID-19 pandemic, had been held at the service since at least February 2021. These were not held securely and had not been administered. Guidance around their administration had not been obtained from people's GP in line with government guidance.
● Guidance had not been provided to staff about when and where to apply prescribed creams to keep people's skin healthy. The application of creams was not recorded. This had been identified as a shortfall in the January 2021 audit completed by a consultant, but again robust action had not been taken to address the shortfall. The provider was not able to tell us why they had not ensured the application of creams was recorded.
● Records of medicines were incomplete and confusing. On occasions no records had been kept to demonstrate if people had taken or refused their medicines and staff were not able to confirm if people had received their medicine. Records of the stock held, and medicines returned to the pharmacy for destruction had not been maintained. These records are important to reduce the risk of medicines being misappropriated. MARs contained duplicate medicines which begun on different dates in the four week cycle. Records of staff signatures were not up to date, to ensure staff can be held accountable for any errors. Poor record keeping put people at risk of harm because instructions were hard to follow and may lead to errors. People may not receive their medicines as prescribed.
● Four people at risk of choking were prescribed thickener to be added to their drinks. Staff used the same tub of thickener, prescribed to one person for everyone. There was no thickener in stock for another person. Prescribed items are the property of the person they are prescribed to and are for their sole use.

The provider had failed to ensure 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.

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

No improvement had been made at this inspection and the provider was still in breach of regulation 18. The provider had not deployed staff to the levels they told us were required to meet people's needs.

● People continued to be at risk because there were not enough staff who knew people well to provide consistent care. In February 2021 the provider sent us an action plan stating 'sufficient numbers of skilled staff are on duty at all times'. This was incorrect and the provider had failed to monitor and manage staffing levels. The majority of experienced staff who knew people well had left the service. They told us this was because of the negative culture at the service. Only one experienced day staff and two experienced night staff remained. New and agency staff had not received an induction into people's needs to ensure care was provided consistently. They did not know people and how they preferred to receive their care and support. Detailed information about people was not available for staff to refer to. The manager was new and did not know people well either.
● The provider's February 2021 action plan also stated, 'three care staff employed during the day working hours between 7am until 8pm'. Staff were not deployed to the levels the provider stated. The number of staff

deployed on each shift was not consistent and rotas did not reflect the staff who had worked at the service. For example, one staff member had not attended their shifts the previous week and the manager had been unable to contact them. They remained on the rota and no cover had been arrange for them. Only one member of night staff was rostered to work on the night of the first day of our inspection. The manager told us agency staff were needed to cover the shift but they had not employed one. This shift was covered at short notice by a member of staff on their day off. The staff member had already worked for at least 19 consecutive days without a break.

● Staff continued to work long hours each week and this went unchallenged by the provider. Timesheets and rotas showed staff worked long shifts without regular days off. Most staff worked six days a week with one day off and told us they were tired. The manager and provider had not monitored staff's practice to ensure they remained competent to fulfil their role.

● Staff rotas were inaccurate and did not reflect who was working at the service. For example, the manager told us they did not know one staff member on the rota and they were not working at the service. Another staff member was off sick but was shown as working.

The provider had failed to deploy sufficient staff to ensure people received consistent care. 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.

● People were not protected by safe recruitment processes. At our November 2019 inspection we found safe recruitment processes had not been followed to ensure staff were of good character. At our last inspection improvements had been made and the provider was no longer in breach of the regulation. At this inspection we found improvements had not been sustained.

● Robust checks had not been completed to ensure staff were of good character. The provider had not obtained a disclosure and barring check for one new employee. Records of checks for a second staff member were incomplete. A third staff member had a disclosure on their DBS. A detailed risk assessment had not been completed to ensure the staff member did not pose a risk to people.

● The provider had led the recruitment of the new manager and had relied on other staff to obtain references. They had not reviewed the refences to make sure they were assured the new manager had all the skills and experience they needed for the role. Recruitment records were not accessible at the service. Records we viewed during and after the inspection showed the provider had not tried to obtain satisfactory evidence of the manager's conduct in previous social care roles or verification of why their employment ended.

The provider had failed to follow safe recruitment processes, to ensure staff were of good character and had the skills required to complete their role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not protected from harm and abuse. Some people told us they did not feel safe living at Roxburgh House. One person told us they had been assaulted by a staff member at the service. We informed the local authority safeguarding team who started investigations. The person had made the same allegations to staff, however, these had not been reported to the local authority safeguarding team or CQC. The provider had not developed an open and honest culture where staff were empowered to raise any safeguarding concerns they had to professional outside of Roxburgh House.

● Some people were scared of other people they lived with. On occasions some people became anxious or frustrated and had behaviours which challenged the staff and other people. Staff and people told us about incidents when one person assaulted had another. Staff told us they had recorded these incidents, but

records could not be found. These incidents had also not been reported to the local authority safeguarding team and people continued to be scared.
● Effective processes were not in operation to review incidents of challenging behaviour to look for triggers, patterns and trends. Records were not clear if health care professionals had been informed of the incidents or if any advice had been provided. Incidents continued to occur, and people were at risk of being hurt.
● Before, during and after our inspection staff told us they had been instructed by the provider not to whistleblow to outside agencies They told us they felt intimidated and were worried about any repercussions. A copy of the provider's whistleblowing procedure was on display at the service however, this was kept in a locked display case and only the front page was on show. A further copy was in an office which staff could not access during our inspection. Staff could not refer to the policy when they needed to.

The provider had failed to protect service users from abuse and improper treatment. This placed people at risk. 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.

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 continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvement had been made, however the provider continued to be in breach of Regulation 12.

● People continued to be at risk from the spread of infection. Rubbish had not been stored safely and securely in the rear garden. This included used personal protective equipment (PPE) which was found lying around the garden and was an infection hazard to people and staff. We reported this to the provider who arranged for this to be moved. Cleaning records continued to show high touch areas, such as door handles and toilet flushes had not been cleaned often and one area was only cleaned once a day.
● COVID-19 risks continued not to be adequately managed. The provider had stopped staff working between Roxburgh House and their other care home since our last inspection, to reduce the risk of spreading COVID-19. However, the providers continued to work at both services. People had not been supported to self isolate for 14 days following hospital admissions, which increased the risk of spreading COVID-19.
● The provider had not ensured improvements to the way soiled laundry was managed had been sustained since our November 2019 Inspection. We found special bags which dissolved in the washing machine were in stock but had not been used to transfer soiled items through the service and into the washing machine. This increased the risk of the spread of infection through the building. We were not assured the provider's infection prevention and control policy was up to date. Individual risk assessments had not been carried out to assess and reduce any impact to people or staff who may be disproportionately at risk of COVID-19. Such as people who have a learning disability or those living with dementia.
● There was plenty of PPE in stock and staff wore this appropriately. However, there was a lack of clinical waste bins for the disposal of PPE. Used PPE was seen in household waste bins and bins did not have lids. This left people at risk from cross contamination and the spread of infection.

The provider 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.

● People and staff were tested for COVID-19 in line with government guidelines. Visitors also completed tests before entering the building.
● At the last inspection, sinks, baths and toilets were stained with limescale and products had not been purchased to remove it. At this inspection, cleaning practice had improved, some sinks and toilets had been replaced. Some bedrooms and corridors had been redecorated and plans were in place for further renovation and redecoration. A relative told us, "They are doing some decorating. It looks a bit tatty on the outside, they are already doing that and spending money, they have done a lot to the garden and bought shrubs and plants".

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 culture at the service continued not to value people as individuals, with skills, life experiences, views and opinions. People were not supported to maintain and develop their independence. The quality of care had not improved, and this was due to a continued lack of leadership and shared direction. We found the provider continued to be out of touch with what was happening at the service and poor care had gone unchallenged.
- The provider had not acted to develop a culture of respect and inclusion for everyone. They did not take responsibility for the shortfalls at the service and a blame culture had developed. Most staff told us they felt intimidated and bullied by the provider and the relationship between the provider and staff had broken down.
- People told us they did not feel valued by the provider, who did not listen to them and stopped them doing what they wanted. For example, going out alone or making their own drinks. We observed the senior management team and some staff did not speak to each other respectfully. People were not treated with respected, for example senior managers shouted at staff in front of people and no one treated the service as people's home.
- Some people's meals were not prepared in a respectful way. Meals were blended or pureed in together and people told us they did not enjoy their meals. Good practice guidance is that foods be pureed separately so people can enjoy the flavour of each food.

Continuous learning and improving care: Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed and 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.

At this inspection, improvements had not been made to the governance processes and the provider was still in breach of Regulation 17.

- People continued to be at risk because the provider had not acted to ensure they had sufficient oversight

of the service. Audits and checks were not robust and had not picked up on many of the issues and concerns identified during our inspection. The provider continued to rely on staff to complete checks but had not checked to ensure these were robust, complete and an accurate.

● The infection control audit dated 10 February 2021 identified some waste bins did not have lids or were not foot operated. No action had been taken to address this. Bins with no lids contained used personal protective equipment. Used personal protective equipment was also found in the garden. This put people and staff at risk of the spread of infection, including COVID-19.

● People were at risk because the provider had not followed the Health and Safety Executive's guidance in managing legionella in hot and cold-water systems. The infection control audit dated 10 February 2021 identified action was required to comply with the guidance. Records did not demonstrate shower heads had been cleaned. Failure to manage the risk of legionella placed people at risk of harm.

● Care plan audits for January and February 2021, identified risk assessments needed to be completed in relation to pressure sores and mental health needs. These had not been completed and there was a risk changes in people's needs would not be identified and care would not be planned to keep them safe and well.

● The health and safety audits were not effective. The flooring around the service was unsafe because it was ripped and torn in places including the hall, lounge, and some bedrooms. The manager's weekly report dated 15 February 2021 identified this. However, health and safety audits carried out by staff in January and February 2021 stated the flooring was suitable and contained no trip hazards.

● Records in relation to the management of the service and people's care were not adequate. Many records and documents were not accessible, including recruitment records. Other records were incomplete and undated. Information about people and their care and support needs was not kept securely and was accessible to other people, staff and visitors in communal areas. On the first day of our inspection archived confidential records were not stored securely. We reported this to the provider, and they were moved to a secure area.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. 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.

At the last inspection the provider had failed to notify CQC 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 had failed to notify us, 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.

Since our last inspection, the provider had not needed to notify us of any absences or deaths at the service.

● 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. The provider had also failed to notify CQC of allegations of abuse so we could check action had been taken to protect people from further risks.

The provider had failed to notify of allegations of abuse. This was a breach of regulation 18 (Notification of other incidents) of the of the Care Quality Commission (Registration) Regulations 2009.
The registered manager had left over a week before our inspection and was no longer working at the service.

The provider had sent us a notification regarding the registered manager but had not provided sufficient information to assure us that they had taken appropriate action to manage the service.

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

At the last inspection the provider 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.

At this inspection, we found some improvements had been made, however the provider was still in breach of Regulation 17.

● People had not been involved, in a meaningful way, in planning changes at the service. Close circuit television had been installed in communal areas of the service, the manager's office and outside the building. The provider told us people had been consulted about this decision. However, people's capacity to give consent to being filmed had not been assessed and discussed. Decisions had not been made in people's best interest by people who knew them well. Records of a residents meeting in February 2021 stated, 'Cameras around the building, except for the bedrooms, were for the security of the residents'. No signs were displayed to inform people or visitors they were being filmed. People's right to privacy had not been respected.
● People's views on the redecoration of the building had not been listened to and acted on. The first floor landing had been painted bright yellow and people told us they did not like the colour. They had raised this at a meeting in February 2021 and the previous registered manager had informed the provider. The provider had not responded to people's feedback and no plans were in place to consult with people and repaint the landing.
● The relationship between the senior management team and staff had broken down. Staff told us they had challenged the provider at staff meetings and urged them to be open and transparent. This was repeated in the previous registered manager's report to the provider in February 2021. However, staff told us they continued to mistrust the provider. They did not feel their views and opinions, based on their knowledge of people, were valued and used to plan improvements. This had led to a lack of trust between the provider and staff.
● Staff had not had the opportunity to share their views through surveys or regular staff meetings. Staff told us they had attended a meeting but they had not been encouraged to share their views. Minutes of the meeting had not been kept.
● At the time of our inspection the provider had begun to ask people and their relatives for their views of the service. Their feedback was mixed. Two people had responded improvement was needed in relation to consultation about redecoration. A relative was not assured staff had the skills they needed, or food was prepared to meet their loved ones needs. Another relative was mostly happy with the care and support received. The provider was collating responses and so had not had an opportunity to address the less favourable feedback.

The provider had failed to act on feedback from people, their relatives and staff to continually evaluate and improve the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had not been open with people's relatives about management changes at the service. Relatives were concerned about changes to the management team and many were unaware the registered manager had left. They told us, "I wasn't informed [the manager] had left, when I phone to see how my relative was, the lady answered and said she was the manager which took me for surprise as I had no idea" and "I have never heard anything from them."
● A number of staff had left the service with little or no notice. The provider had not told people and relatives staff they knew well had left. One relative said, "I sometimes feel there could be more communication. Care homes are sometimes quite secretive. This applies to Roxburgh. Carers arrive or go, and we are not told what happened, they just disappear. It is relative's home; it would be nice for them to know more. My relative gets used to a particular carer and they just disappear."
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the main entrance to the service.

Working in partnership with others
● The previous registered manager had worked closely with the health care professionals such as community nurses and people's GP. The new management team had not yet begun to build working relationships with local health and social care professionals to support people's changing needs and develop the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify of allegations of abuse. 18(1)(2)e)

The enforcement action we took:

We applied urgent conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people from risks related to fire. Risks related diabetes, catheters, choking, epilepsy and behaviour which challenged had not been assessed and care had not been planned to keep people safe. The provider had failed to ensure staff followed safe and consistent processes when managing medicines. The provider had failed to ensure the building and equipment were maintained and kept clean. 12(1)(2)(a)(b)(d)(g)(h)

The enforcement action we took:

We applied urgent conditions to the provider's registration.

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 The provider had failed to protect service users from abuse and improper treatment.

13(1)(2)(3)

The enforcement action we took:

We applied urgent conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. The provider had failed to act on feedback from people, their relatives and staff to continually evaluate and improve the service. 17(1)(2)(a)(b)(c)(d)(e)

The enforcement action we took:

We applied urgent conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to follow safe recruitment processes, to ensure staff were of good character and had the skills required to complete their role. 19(1)(a)(b)

The enforcement action we took:

We applied urgent conditions to the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient staff to ensure people received consistent care. This left people at risk of harm. 18(1)

The enforcement action we took:

We applied urgent conditions to the provider's registration.