Meridian Healthcare Limited

Roby House Care Centre

Inspection report

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14 July 2021
21 July 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Roby House Care Home provides accommodation, personal and nursing care for up to 55 people in one adapted building over two floors with lift access to the upper floor. At the time of our inspection 53 people were living at the service.

People's experience of using this service and what we found
Risk to people's safety was not always assessed and managed. Some people did not have access to a nurse call bell and others did not have the ability to operate one, however measures were not taken to identify and mitigate risk.

We were not fully assured that Infection prevention and control measures were followed to minimise the risk of the spread of infection. Equipment used to support people and some carpets and furnishing were dirty and unhygienic. Cleaning schedules for equipment had not been followed and daily checks failed to identify and mitigate the risk of the spread of infection.

We have made a recommendation about staffing. People were kept safe by the right amount of staff; however, the deployment of staff was not always effective to fully meet people's needs.

Medicines were managed safely. Staff with responsibilities for managing medicines were suitably trained and competent.

The recruitment of staff was safe. A range of pre- employment checks were carried out to assess applicants fitness and suitability for the role.

Managers and staff understood their responsibilities for protecting people from the risk of harm and abuse. Allegations of abuse were well managed. People told us they felt safe and staff treated them well.

Checks on the quality and safety of the service were not always effective in identifying and mitigating risk. Some required checks had not taken place and others failed to pick up on areas for improvement.

Care was planned in a way that promoted person-centred care, however the delivery of care was not always person-centred which impacted on the quality of care people received.

People, their representatives and staff were involved and engaged and there was good partnership working with others. Information about events and changes to the service was shared with relevant others in a timely way.

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 good (published 19 October 2018).
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roby House Care Centre on our website at www.cqc.org.uk.

Why we inspected
We received concerns in relation to people's safety. 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. 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 changed from good to requires improvement. This is based on the findings at this inspection.

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.

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 safe findings below.

Roby House Care Centre

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.

Inspection team
We visited the service over two days. One inspector and a dementia care specialist nurse advisor (SpA) visited on the first day and one inspector visited on the second day.

Roby 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 announced the inspection visit from the car park prior to us entering the service. This was because we needed to obtain information about COVID-19.

Inspection activity started on 14 July 2021 and ended on 21 July 2021. We visited the service on 14 July and 21 July 2021.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed the information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our

inspection.

During the inspection
We spoke with ten people who used the service and four family members about their experiences of the care provided. We also spoke with the registered manager, members of staff including care workers, ancillary staff and the maintenance person. We reviewed a range of records. This included people's care records and multiple medication records. We looked at the recruitment files for staff employed since the last inspection.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. We requested records and documentation to be sent to us and reviewed these following the inspection visit.

We continued to seek clarification from the provider to validate evidence found. We reviewed a range of records relating to the safe management of the service including audits, safety checks and staff recruitment and training records.

Requires Improvement

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 good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risks to people's health, safety and welfare was not always assessed, monitored and managed.
- Some people who occupied their bedrooms did not have access to a nurse call bell. This was either because there was no call bell available or because sensor mats in use for people at risk of falls were plugged into the nurse call bell socket. The use of an adapter to operate both had not been considered to minimise risk.
- Some people being cared for in bed did not have the ability to operate a call bell, however no risk assessment had been completed to establish risk and how this should be monitored and managed. Staff assured us they carried out regular checks to ensure the safety of people unable to operate a nurse call bell however, the checks were not recorded.
- Staff were provided with training and information about infection prevention and control (IPC), however we were not assured good practice was being followed to minimise the spread of infection.
- Equipment being used on the second day of inspection was unclean placing people at risk of the spread of infection. Wheelchairs, easy chairs, walking frames and crash mats were heavily stained with food debris, dust and spillages. Some carpets and furniture in people's bedrooms were heavily stained and worn in parts.
- Staff had not followed the required cleaning schedules for equipment used to support people. This was evident through our observations on the second day of inspection and on checking cleaning records which were incomplete.

We found no evidence that people had been harmed however, the provider failed to assess and mitigate risks to the health and safety of service users. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safety checks were carried out by a suitably qualified person at the required intervals on utilities, fire systems and equipment.
- People, staff and visitors took part in a COVID-19 testing programme and testing records were maintained.

- There was a good supply of personal protective equipment (PPE) located around the service and staff used and disposed of it safely.

Staffing and recruitment

● There were enough suitably skilled and experience staff on duty to keep people safe. However, staff reported they often felt under pressure to fully meet people's needs.
● Staff deployed to assist with mealtime preparation and to support people with eating and drinking throughout the day were not replaced when they were absent from work. Care staff told us this meant they had to fulfil the role which impacted on the time they could spend with people. Staff told us they often felt rushed and unable to spend quality time with people. Staff comments included; "Can be days where we are still doing personal care from the morning at lunch time" and "Not enough staff. Can't give the care people need."

● We observed limited activities and meaningful interactions taking place with people. This was because care staff were busy with other tasks and there was just one member of staff dedicated to organising and facilitating activities for people on both floors.

We recommend that the provider review staffing arrangements in line with people's care and support needs.

● Safe recruitment processes were followed. Applicants were subject to a range of pre-employment checks to make sure they were fit and suitable for the role.

Using medicines safely
● Medicines were safely stored, administered and disposed of.
● Staff responsible for the management and administration of medicines completed the required training and underwent regular checks to make sure their practice was safe.
● Each person had a medication profile and a medication administration record (MAR) detailing their prescribed medicines and instructions for use

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded from the risk of abuse. Allegations of abuse were properly managed.
● Staff completed safeguarding training and had access to the providers and local authorities safeguarding procedures. Staff were confident about recognising and reporting allegations of abuse.
● People told us they felt safe and were treated well. Their comments included; "Oh yes I feel safe and they [staff] are kind and caring" and "I've no worries about the way they [staff] treat me, they keep me safe." Family members told us they were confident their relative was safe from the risk of abuse.

Learning lessons when things go wrong.
● Incidents were recorded and reported in line with the providers procedures.
● Incidents were analysed so that learning could take place to prevent or reduce further occurrences.

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service was not consistently managed and well-led. 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; Continuous learning and improving care

- The provider had systems and processes for checking the quality and safety of the service, however, they were not always used effectively to identify and mitigate risk, and bring about improvements to the service people received.
- Some checks were not carried out as required and others failed to identify and mitigate risks to people's health and safety. This included checks carried out on nurse call bell and the cleanliness of equipment.
- Records of daily walk arounds showed they had not been carried out each day as required. Records of those that had taken place made no reference to checks carried out on equipment or nurse call bells, despite these being identified on the checklist as areas to be checked.
- The manager took up post in January 2021 and they had a clear understanding of their role and responsibilities. However, they had recently provided management support at a sister service and felt this had impacted on the management of Roby House.
- Staff described the manager as supportive and approachable and commented they felt they did their best. Staff commented that the manager wanted to improve things such as the environment and staffing but "felt their hands were tied" because things had to be agreed by more senior managers.
- The manager acknowledged the need to make improvements based on our findings. They took prompt action during and after the inspection to make the required improvements.

Planning and promoting person-centred, high-quality care and support with openness

- Care was planned in a way that promoted person-centred care, however the delivery of care was not always person-centred.
- The use of unclean equipment and lack of monitoring people's safety was not person centred and led to unsatisfactory outcomes for people.
- The deployment of staff was not always effective in ensuring people received person-centred care. People did not always receive the care and support they needed to fully meet their needs.

We found no evidence that people had been harmed however, the provider failed to operate effective systems to ensure the safety and quality of the service. This was a 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; Working in partnership with others

● People, their representatives and staff were provided with the opportunity to express their views and opinions using surveys. Surveys were provided in various formats making them easily accessible to people and others.

● Family members told us they felt involved in their relative's care and were provided with regular updates.

● Updates about people's needs and any changes to the service were shared with staff through daily handover and flash meetings.

● Managers and staff made appropriate referrals to other agencies where this was required for people. They worked in partnership with relevant others in the best interest of people.

How the provider understands and acts on duty of candour responsibility

● The provider understood and acted upon their duty of candour. Investigations took place were this was required, and any learning was shared across the staff team.

● The provider notified relevant others as required of any changes to the service, incidents and events.

● The last CQC inspection rating was displayed at the service and on the provider's website.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and mitigate risks to the health and safety of service users. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to ensure the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.