St Philips Care Limited

Roxholm Hall Care Centre

Inspection report

Roxholm
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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

We carried out an unannounced comprehensive inspection of this service on 24 August 2015. After that inspection we received concerns in relation to the care being unsafe and risks not been appropriately identified and managed. In addition concerns were raised that medicines had not been administered as prescribed. We also had concerns that the registered manager was not managing the home well as they had not identified these concerns. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Roxholm Hall Care Centre on our website at www.cqc.org.uk.

The home provides residential care for up to 39 people who require care due to old age, living with dementia or mental health needs. It is located in the countryside four miles north of Sleaford in Lincolnshire.

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had trained staff to understand when people were at risk of harm and cooperated with the local safeguarding authority to fully investigate any concerns raised. Risks to people when receiving care had been identified and care pans contained information on how to keep people safe. However, at times the information did not support staff to provide person centred care.

The provider had systems in place to assess the number of staff needed to provide safe care for people. However, at times people were left alone and care was not provided in a prompt manner. Medicines were stored and administered safely. However, care plans did not support staff to provide as required medicines in a person centred way. Staff had completed the medicine administration records but did not always fully complete other records associated with medicines.

The provider had reviewed the management structure for the home following the recent referrals to the local safeguarding authority as the management team had failed to identify concerns about the quality of care being provided. The changes made appeared to be positive, however,given the improvements had recently been made we needed assurance that these could be sustained over a period of time.

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 consistently safe.

The provider had engaged with the local authority to fully investigate safeguarding concerns and took appropriate action to keep people safe.

Care plans contained information on how to keep people safe from the risks associated with care. However, at times care plans did not contain enough information to support people in a person centred way.

The provider had systems in place to review the needs of people living at the home and how many staff were needed to meet those needs. However, at time people were left unsupported.

People's medicines were safely stored and administered. however, messages relating to medicines were not always accurately handed over to staff.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had made recent changes to the management of the home to help identify issues. Time was needed to see if the changes embedded in to the home and continued to identify problems.

Staff, people living at the home and relatives told us the registered manager and deputy manager were supportive and responded when concerns were raise.

The provider had systems in place to gather the views of people living at the home and their relatives.

We could not improve the rating for well led from requires

because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Roxholm Hall Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 May 2016 and was unannounced. It was a focused inspection as we had concerns about the safety of the care people were receiving. This was because a number of safeguarding concerns had been raised by visiting healthcare professionals. We looked at the key questions of is the safe and is the service well led. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with seven people who lived at the service, three visitors to the service and spent time observing care. We spoke with the registered manager, the area manager, the deputy manager, a senior care worker and a care worker.

We looked at five care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People told us that they mainly felt safe living at the home and that they were supported to be safe by the staff. A person living at the home told us, "Up to now I feel safe. There's always someone around if I call out." A relative told us, "100% happy she's safe. Everyone's got time for her. The transition moving in here was spot on too." However, a number of people told us they were worried that people living with dementia did not recognise personal boundaries and would go into other people's bedrooms.

Prior to our inspection the provider informed us about a number of safeguarding concerns that had been raised with the local authority by visiting health care professionals. We saw that the registered manager and staff had worked collaboratively with the local authority to ensure that the concerns were thoroughly investigated. We saw that they had identified that the care plans had not fully described the person's care needs and had retrospectively entered more information to show that care was meeting people's needs and that health care professionals had been involved in people's care. Following the investigation the local safeguarding authority had made recommendations about actions the provider needed to take to keep people safe. The registered manager had acted upon these recommendations.

Staff we spoke with knew how to raise concerns about people's safety and were confident that the registered manager would listen to those concerns and take appropriate action. In addition staff had access to information on how to raise concerns with the local authority and the telephone number for the local authority was on display in the office.

Some risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Appropriate equipment was in place to reduce the risk of occurrence. Risks around supporting people to move safely had also been identified and people told us they felt safe when staff assisted them to move. We saw that staff supported a person to move using equipment and that it was done safely and in a way which would reduce the risk of injury to people living at the home and staff. They staff reassured the person what happening and what they would be doing next. Care plans contained information to support staff should people become distressed when using equipment.

However, we saw at times that care plans did not fully support staff to reduce the risk of people hurting themselves when in a distressed state. For example, one person's care plan recorded, "Deal with as trained." There was no personalisation to help staff understand what activity the person found calming.

We also saw that some care planned to keep people safe was not always in place. For example, one person who was identified as being at risk of falls had a pressure mat near their chair. This was a mat which was linked to the call bell system and which would call for staff if the person stood up. However, while we were walking around the home we saw the mat was unplugged even though the person was sitting in their bedroom. We discussed this with a care worker who told us it had been unplugged as it was broken and ringing constantly. We asked them to plug it back in and it worked correctly.

We discussed the risks associates with catheter care with the deputy manager and when they would raise concerns. The deputy manager and one member of staff were clear on the process and that they would refer to a healthcare professional after monitoring for two to four hours. However, another member of staff we spoke with thought that they should wait 24 hours before raising any concerns. We discussed this with the registered manager who said that they would once again review the training around catheter care.

We saw that monitoring charts were being appropriately completed. The deputy manager told us that this was an area that they had been focusing on as they were not always being accurately completed. Where people's needs had changed risk assessments were reviewed. For example, we saw that when a person had a fall their falls risk was reassessed. However, we saw that some people did not have corresponding care plans when a risk had been identified.

We found the registered manager had completed a staffing tool to help them identify the numbers of staff needed to provide safe care for people. This showed that they needed to have five staff on during the day and four at night. Records showed that the home was staffed in accordance with the tool. Staff told us that most days there was enough staff working to meet people's needs, but that at times they did not have time outside of their care tasks to interact or chat to people.

We spent time observing care and saw that at times people in the lounges were left unsupported for half an hour at a time. For example, seven people were left in the upstairs lounge by staff from 2pm until 2.30pm. One person stood and left the room for a short time and returned saying, "Nobody's about" and sat down again. When a staff member appeared they walked across the room to collect a file, said, "Cup of tea in a minute…" and left the room again, with no interaction or reassurance. One person who spent time in their room told us, "They're very short staffed. I have to go and find someone if I'm down here [in my bedroom]." Another person told us, "The staff are marvellous but not enough of them. They've got a lot of people to look after so I don't like to bother them"

During the inspection we heard call bells in use and saw staff going to attend to a person without lengthy waits. However, people we spoke with told us that, at times, they had to wait too long for support, particularly when the toilet is needed. One person told us "I can have a long wait for the toilet – it can be 45 minutes after ringing the buzzer. Sometimes they come in and cancel it and come back when they can. I've been left on my commode for more than 20 minutes and they've not come back – it's a long time when you're just waiting." Another person said, "I've had two accidents lately as I'm not padded and couldn't hold it as they didn't come in time. I had to use tissues to try and soak it up."

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who lived at the service.

People told us they were happy with the way their medicine was administered. One person told us, "They make sure I take them [tablets]." Two senior care workers completed the medicine rounds, one on each floor of the home. This helped to ensure the medicine round was completed quickly and people did not have to wait for their medicine. Staff were aware of people's individual medicines needs and ensured that medicines were given at appropriate times. An example of this was two people who needed their medicines half an hour before their breakfast.

Records shows that staff had recently received training in the safe administration of medicine. Registered

manager and deputy manager completing observations of people who administer medicines to check they were competent. Systems were in place to manage medicines safely and to ensure that they were available to people when needed. For example, medicines such as creams and eye drops were dated when opened and staff had accurately completed the Medicine Administration Records(MAR) recorded. However, at times we saw staff did not follow the systems to manage people's medicines safely. For example, skin patch application records were not always completed accurately. In addition care plans did not identify where people were known to repeatedly refuse medicine or that advice had been obtained from the GP about which tablets were more important.

We saw the care plans did not always support staff to administer medicines in a person centred way. For example, information related to pain medicine prescribed to be taken as required did not identify if people could inform staff when they were in pain or if staff should respond to non-verbal signs. We saw most people were asked if they were in pain. However, we saw one person was given as required medicine without being asked. The senior care worker said that recent information in the communication book had requested that the medicine be given every day. This was because the person was unable to recognise if they needed pain relief when asked. However, we checked the communication book and raised this with the deputy manager who said that the person was able to understand and respond to questions if staff took their time and communicated clearly. The registered manager told us they would speak to staff about the medicines for this person.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of the service provided. However, we found that these systems had failed to identify serious concerns which were raised with the local safeguarding team. We discussed the safeguarding concerns with the registered manager and the area manager. They had an understanding of why the service had not been providing the high quality of care they wanted to give to people. They had also reviewed the management systems and now understood why they had not recognised this before concerns were raised with the local safeguarding authority. They had taken action to give the registered manager more time to monitor the quality of service and to make changes if the quality of care was declining.

They had employed a new deputy manager for the home, who had been promoted from senior carer and knew the needs of people living at the home. The deputy manager had been in post for three weeks and the provider had identified the training needed to make then an effective support for the registered manager. However, we were concerned as this was the same process used for the previous deputy who did not develop the skills needed to fully support the registered manager. We discussed our concerns with the registered manager and the area manager. They were confident that they had robust training plans to support the new deputy manager and systems to monitor their performance.

The deputy manager was auditing the care plans and monitoring forms including the medicine administration records on a weekly basis. They told us that staff had not been fully completing the monitoring forms as they had not fully understood their importance. Systems had been put in place which required the senior care worker on each shift to take responsibility for ensuring that care had been appropriately delivered. Records we checked showed forms had been appropriately completed and that all care was being delivered in line with people's care plans. However, the deputy manager had only been in post for three months so more time was needed to show if the processes they had put in place embedded into everyday practice and continued to provide an accurate reflection of the care people received.

Staff told us that things had improved since the new deputy manager had taken over some of the management roles. One member of staff told us the new deputy was making a big difference and that they could go to her with issues and she would sort them out. In addition the new deputy manager was still working on the floor to lead by example.

In addition staff were supported to improve the quality of care they provided with regular staff meetings. The registered manger and deputy manager told us how they used the meetings to raise issues with staff that had been identified through the safeguarding investigations and ongoing audits. For example, records showed that staff had been reminded to complete the professional visit notes. All staff were therefore able to access the information about changes in care that visiting health professionals had recommended for people. Staff meeting minutes were available in the office for all staff to read.

People told us that they were happy with the registered manager. One person told us, "She's around and about and I can talk to her easily." a relative said, "They know me now and I'm always made welcome. I

speak to her often and she's very easy to chat with."

The registered manager said that they did not hold relatives' meetings as they had tried before and no one had attended. Monthly residents' meetings were held with the activity co-ordinator. Records shows that they discussed items such as planned entertainment and the quality of the food offered.

People using the service, their relatives and visiting health care professionals had been asked for their views on the service in a survey. We saw that the results were displayed on the notice board for people living at the service, relatives and visitors to see. The registered manager was working on an action plan in regard to the feedback received through the survey.