Roshini Care Home Ltd

Roshini Care Home

Inspection report

25-26 Villiers Road
Southall
Middlesex
UB1 3BS

Tel: 02085743663
Website:
www.carehome.co.uk/carehome.cfm/searchazref/10001010ROSQ

Date of inspection visit:
17 November 2020

Date of publication:
05 July 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Roshini Care Home is a residential care home which provides accommodation and personal care for up to 11 men and women with mental health needs in one adapted building. At the time of the inspection there were 11 people living at the home.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Individual risks management plans for specific risks relating to people's health and wellbeing were not always in place. This meant care workers were not always provided with adequate guidance as to how they could reduce possible risks to people.

The provider had an infection control process in place but this was not always followed to ensure infection control practices were implemented effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's care plans did not always provide accurate and up to date information in relation to their care and support needs. This meant there were risks that people's needs would not always be met.

The provider had a range of quality assurance processes, but these did not always assist the provider to identify areas requiring improvement.

The provider did not ensure notifications were sent to the Care Quality Commission in line with regulatory requirements.

The provider had made improvements to the reporting of safeguarding so that where a safeguarding concern had been identified it had been reported to the local authority safeguarding team.

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 December 2019). 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 targeted inspection to check whether the provider had met the breaches of regulation 9 (Person centred care), regulation 11 (Need for Consent), regulation 12 (Safe Care and Treatment), regulation 13 (safeguarding service users from abuse and improper treatment) in addition to checking whether the provider had met the requirements of the Warning Notice in relation to regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 person centred care, need for consent, safe care and treatment and good governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Roshini Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on whether the provider had met the breaches of regulation 9 (Person centred care), regulation 11 (Need for Consent), regulation 12 (Safe Care and Treatment), regulation 13 (safeguarding service users from abuse and improper treatment) in addition to checking whether the provider had met the requirements of the Warning Notice in relation to regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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
The inspection was carried out by two inspectors.

Service and service type
Roshini Care Home 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 because it is a small service and we needed to be sure that the provider or registered manager would be available to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last 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 used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, deputy manager and senior staff. We reviewed a range of records. This included six people's care records and we looked at records relating to infection control. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the regulations which were breached at the previous inspection. We will assess all of the key question at the next comprehensive inspection of the service.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection, people were at risk of not receiving their care in a way that reduced possible risks. 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 was still in breach of regulation 12.

• Risk management plans were not always in place where a specific risk related to a person's health and wellbeing had been identified. This meant care workers were not always provided with guidance on how they could support the person to reduce possible risks.
• For example, we saw that if a person had been identified as living with diabetes there was a generic information sheet providing guidance on the condition. However, this guidance sheet did not provide any information specific to the person's care needs in relation to the medical condition.

This meant the provider had failed to robustly assess the risks relating to the health, safety and welfare of people and provide guidance for care workers on how to reduce possible risks. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At our last inspection the provider had failed to monitor incidents and accidents to ensure appropriate action was taken. 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 was still in breach of regulation 12

• When a record had been completed after an incident and accident had occurred the actions that had been taken were not always recorded to help reduce the risk of reoccurrence.
• Incident and accident forms were not always completed when an issue was identified. For example, we saw information on an incident had been recorded in the daily records of care completed by care workers. This information had not been recorded through the incident and accident procedure so that appropriate actions could be identified to reduce possible risks.

This meant incidents and accidents had not always been monitored to ensure appropriate action was taken and the provider had not identified trends and patterns so the risk of reoccurrence could be reduced. This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Infection control procedures were not always followed. Care workers did not have COVID-19 risk assessments or risk management plans in place.
• Risk assessments for people using the service did not always provide detail or a specific plan of how to mitigate risks relating to covid-19. For example, one person's risk assessment in relation to visitors stated due to COVID-19, staff needed to accompany the person when they went out, but further in the document it stated under COVID-19 guidance that 'The person was to stay in their room or go into the lounge where chairs have been placed to maintain social distancing. Meals have been staggered to ensure no more than two residents sit at the table at one time.'
• We saw the furniture in communal areas was generally spaced apart to promote social distancing. However, we saw the chairs at the dining room table were not spaced out to reduce contact with others. At lunch time, we observed seven people sitting at the dining room table, side by side with no distance between them. We asked the registered manager if meal times were staggered and they confirmed that they were not so they could maintain the family feel for meals. This meant the guidance provided for care workers did not relate to how support was provided.
• During the morning of the inspection, we observed a care worker in the communal lounge was not wearing their mask correctly as it was hanging off one ear instead of across their face and on both ears.

We found no evidence that people had been harmed however, processes for infection prevention and control were either not in place or robust enough to demonstrate infection control was effectively managed. 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.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13 in relation to safeguarding.

• At the previous inspection we saw the provider had a procedure in place to investigate concerns regarding the care provided, but this was not always followed as we identified a concern was not reported.
• At this inspection we saw that where a safeguarding concern had been identified it had been reported to the local authority safeguarding team and there were copies of correspondence to evidence this. However, it had not been recorded as a safeguarding incident in the provider's records in line with their procedure. The registered manager confirmed safeguarding concerns would be recorded as per the provider's process

in future.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breaches of regulation we found at the previous inspection.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

• The provider did not always ensure the principles of the MCA were followed and mental capacity assessments did not clearly identify if the person had the capacity to consent to their care. For example, we saw one person's medicines administration mental capacity assessment indicated they did not have capacity to make decisions about the administration of medicines. There was a consent form dated the same day as the mental capacity assessment where the person had signed to consent for their medicines to be ordered and administered by staff at the home.
• The mental capacity assessment for another person in relation to medicines administration also indicated the person did not capacity to enable them to consent to their medicines being administered but the person

had signed a consent form. This meant in both examples it was not clear if the person did or did not have the ability to consent to their medicines being administered to ensure this met with the principles of the MCA.
• The registered manager confirmed people living at the home had received COVID- 19 testing. We saw that where a person had been identified as not having the mental capacity to consent in the rest of the care plan there was no record of a mental capacity assessment and best interest decision being made for the COVID-19 testing.

This meant people were deprived of their ability to make choices. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breaches of regulation we found at the previous inspection.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure the care plans always provided care workers with up to date information regarding people's care needs. This was a breach of regulation 9 (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 was still in breach of regulation 9.

• The information and guidance provided for care workers in care plans did not always reflect the support needs of the person. The care plan folder for one person included a form for staff to record when the person experienced a hallucination but there was no indication in the care plan that this form should be completed and what should be done with the information.
• The care plan for a second person had not been reviewed and updated to include changes to their health and support needs following an extended admission to hospital. This meant that care workers did not have access to up to date information on how they should support the person.
• The care plan for another person had not been updated following an episode of behaviour which could be challenging to ensure care workers understood how to best support the person.

This meant people may not have been receiving the support they required because care workers were not provided with up to date information on people's support needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

Continuous learning and improving care

At our last inspection the provider did not have an effective quality assurance process in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had a range of quality assurance processes in place, but these were not always robust enough to identify where improvements were required. A monthly care plan audit was carried out by the random selection of care plans with no set number to be reviewed per month. We saw that some care plans had not been audited for a number of months. For example, the care plan audit record for one person showed an audit was last carried out in March 2020. This meant the provider did not have a robust process in place to enable them to identify when care plans were not accurate.
• We saw the provider was following their safeguarding procedure by reporting concerns to the local authority safeguarding team, but we noted that they were not always recording the concern as a safeguarding in their own records. Information in relation to a concern was recorded in a person's care plan folder but not as a safeguarding under their process. This meant the provider could not monitor and review the outcome of the referral to identify if appropriate action was taken to reduce the reoccurrence of risk and if their procedure was followed.
• A monthly audit was carried out to review the recording of accidents. We saw that that no accidents were reported in October 2020 but the audit stated they had been recorded appropriately with the response of yes to if there was a trend in accidents and incidents. This meant the information recorded in the audit did not reflect how the accidents were recorded or provide an accurate overview so improvements could be made.

Therefore, the provider did not have a quality assurance process in place that was always effective. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• An annual check was carried out of the water systems to monitor for legionella. A fire safety audit and risk

assessment were completed quarterly for the home.

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

• The provider did not ensure they complied with the regulatory requirements. During the inspection we saw there had been one incident that involved the police attending to resolve the issue. Providers are required to send the CQC a notification when there is any police involvement in relation to a person receiving the regulated activity.

• The provider is also required to send notifications to the CQC when a DoLS authorisation has been received. We identified that three people had DoLS authorised by the local authority during 2020. The provider did not ensure these notifications had been sent.

• Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify the CQC about.

• The registered manager confirmed they had not sent notifications relating to the police incident and the DoLS authorisations at the time they occurred. The meant the registered manager had not complied with the regulatory requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering our regulatory approach regarding this breach.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 as they did not ensure service users' mental capacity was assessed and recorded where they were unable to give consent. Regulation 11 (3)

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 12 HSCA RA Regulations 2014 Safe care and treatment The risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. Regulation 12 (1) (2)

The enforcement action we took:

We have issued a Warning Notice requiring the provider and registered manager to comply with Regulation by 15 February 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have appropriate checks in place to assess, monitor and mitigate the risks relating health, safety and welfare of services. Regulation 17 (1)(2)

The enforcement action we took:

We have issued a Warning Notice requiring the provider and registered manager to comply with Regulation by 15 February 2021.