Discovery Care Limited

Roxburgh House

Inspection report

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Kent
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Tel: 01843832022

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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
Roxburgh House is a residential care home providing personal care to 11 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
The service people received had improved since our last inspection, however further improvements were required to address two continued breaches of regulation and bring the quality of the service people received up to a good standard.

Staff were not always recruited safely and robust checks has not been completed on their conduct in previous roles. Records of the care people received had improved, however, there remained gaps in records and some information about people was contradictory.

People were not fully involved in planning what happened at the service. They had been asked for their views, but these were not always acted on. People were not supported and encouraged to develop and maintain their independence and staff completed day to day tasks for people rather than with people.

Some relatives reported communication with the provider and manager had improved. Others had not been made aware there was a new manager and felt communication about changes in their relatives needs and the service could be more effective.

Risks relating to people's care had been assessed and care had been planned to mitigate these. However, further work is needed to involve people in planning how to take and manage risks.

There were enough staff on duty, and they had completed training in key areas such as safeguarding and medicines management. Staff knew how to identify signs of abuse and raise any concerns they had. Medicines were now managed safely.

The building was clean and work had been completed to improve the access and decoration of the building.

We have made recommendations about safeguarding investigations, gathering and acting on people's views and to maximising people's choice, control and independence.

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 16 June 2021) and there were multiple breaches of regulation. We took urgent action against the provider to stop any new people moving into the service. We

also required the provider to tell us how they had mitigated risks to people. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement or inadequate for the last four consecutive inspections.

This service has been in Special Measures since 13 November 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 17 August 2021. Breaches of legal requirements were found. We undertook this focused inspection to check the provider had taken action and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. 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 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 staff recruitment and record keeping at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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 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 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 two 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 service had a manager in post, they were not registered with CQC which meant 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 and professionals who work with 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 four people who used the service about their experience of the care provided. We spoke with eight members of staff including the nominated individual, manager, deputy manager, care workers and the chef.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with three relatives about their experience of the care their loved ones received. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance 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 inadequate. At this inspection this key question has now improved to requires improvement. 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.

Staffing and recruitment
At our last inspection 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.

Enough improvement had not been made at this inspection and the provider continued to be in breach of regulation 19.

● People continued not to be protected by safe recruitment processes. The provider's recruitment policy required them to obtain two employment references for new staff. They had not obtained satisfactory evidence of staff's conduct in all previous health or social care roles as required by the Health and Social Care Act 2008. One staff member had previously held a social care role, but no checks had been completed on their conduct or reasons for leaving the role.

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

● Other checks on new staff, including disclosure and barring checks had been completed. Recruitment records were held at the service and were accessible at the service.

At our last three inspections the provider had failed to deploy sufficient numbers of staff 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● There were enough staff to meet people's needs. At our last inspection, timesheets and rotas showed staff worked long shifts without regular days off. Staff rotas were inaccurate and did not reflect who was working at the service. At this inspection the provider had recruited new staff and deployed staff based on their skills. One person told us, The staff are more courteous, more attentive and there are more of them".
● The service was staffed appropriately on the day of inspection; the staff present corresponded with staff rotas. Staff rotas showed staff no longer worked excessive consecutive periods. The manager used a

dependency tool to assess people's care needs and calculate the staff hours required to meet them. One person told us they no longer had to wait for support.
● Staff had received training relevant to people's needs. This included training in mental health, diabetes, epilepsy and behaviour which can challenge. Staff felt they knew people well and were confident in meeting their needs. Relatives felt staff knew people and their needs well. One relative commented they felt there were more staff at the home than when they had previously visited. Another relative felt staff were friendly and communication had improved.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to protect service users from abuse and improper treatment. 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. Incidents had been reported to the local authority safeguarding team and staff were now confident to blow the whistle to outside agencies when they have concerns.

● During the inspection some people told us their money was looked after by the manager. People had accepted this situation because they felt there was no alternative. One person told us they would like to hold money in their bedroom but no lockable space to keep money or valuables had been provided. There were no locks on bedroom doors. In discussion with the nominated individual and manager, we were told they would review this situation.
● Since our last inspection safeguarding concerns had been raised to the local authority safeguarding team and the manager had been asked to complete investigations into these. These investigations had not always been robust and the manager had not considered the wider implications for everyone living at the service. For example, concerns were raised about the continence care received by an unnamed person with particular needs. The manager responded that no one had those needs at the service but did not consider the possible risks of everyone who required support with the continence.
● Some people had left the service following our last inspection. People told us the service was now calmer. One person told us they now felt more relaxed at the service and were no longer scared of other people.

We recommend the provider consider current guidance in relation to investigating safeguarding vulnerable adult concerns and supporting people to safely manage their own finances.

● The culture amongst staff and people had improved. Staff and people were encouraged to report concerns. Staff were confident any concerns reported would be treated appropriately and believed the culture within the service had improved. Safeguarding and whistleblowing policies promoted transparency and accountability, this was supported by the provider.
● Our review of incidents showed behaviours which challenged and other incidents of concern were recorded, analysed and acted upon. The manager had reported concerns to the local authority safeguarding team and worked with them during their investigation processes.

Assessing risk, safety monitoring and management
At our last three inspections the provider had failed to protect people from risks related to fire and the environment. Risks related to diabetes, catheters, choking, epilepsy and behaviour which challenged had not been assessed and care had not been planned to keep people safe. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. At our previous inspections we found some people living at Roxburgh House were at risk of serious harm. Since our last inspection three people with complex needs had left the service.

● Care provided to people with epilepsy or who had seizures had improved. Information was now available to staff about the action required to keep people safe, including when to call for emergency medical support. One person's care plan stated they were not at risk of drowning if they were left unsupervised in the bath. This was not correct and having a seizure increased risks to the person. The manager had incorrectly recorded the risk. Staff told us they did not leave the person alone in the bath.
● Since our last inspection guidance had been provided to staff about how to care for people's catheters. This included how to identify if they were not draining and when to inform health care professionals. Any concerns had been reported appropriately. People's fluid intake had been planned to keep the catheter flowing well. However, records showed one person did not always drink enough and drinks were not offered frequently as required by their care plan. The manager had reminded staff several times, to encourage the person to drink more but staff had not followed this instruction. The manager had not taken further action to ensure the person always drank enough.
● Speech and language therapists had reviewed people at risk of choking since our last inspection. They had provided guidance to staff about how to prepare people's food and drinks to reduce the risk of them choking. We observed meal and drinks were prepared as required.
● Staff knew what may cause people to become anxious or distressed. Guidance was in place about how to support people to remain calm. Incidents at the service had reduced.
● At our last inspection we found one person was not supported to live well with diabetes. They were not offered a low sugar diet and staff had not acted when their blood glucose levels were high. At this inspection no one was living with complex diabetes.

Using medicines safely
At our last three 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. Medicines management processes had improved, and medicines were managed safely.

● Some people were prescribed medicines 'when required', such as medicines for symptom relief. Since our last inspection, guidance had been put in place about how when people needed the medicine and how often it could be taken. The time people had taken 'when required' medicines had been recorded, so staff knew when it was safe to administer a further does.
● Action had been taken to ensure people received their medicines as prescribed. Since our last inspection staff had consulted with people's GPs and people were now taking vitamin D drops. Two people at risk of choking were prescribed thickener to be added to their drinks. Stocks of thickener were in place for each person and staff no longer used the same tub of thickener for everyone.
● At the last inspection, guidance had not been provided to staff about when and where to apply prescribed creams to keep people's skin healthy. The application of prescribed creams was now being recorded. However, there were are a few gaps in the records, this was an area for improvement. Records of the administration of other medicines had improved, including records to confirm medicated patches had been applied. Records kept of medicines returned to the pharmacy had also been maintained.
● The pharmacy supplied some medicines in monitored dosage systems and others in their original packaging. Staff maintained a record each day of the number of boxed medicines in stock and these were

checked weekly to identify any errors. This system had been effective and stocks levels matched the stock balance recorded.

Preventing and controlling infection
At our last two inspections the building and equipment had not been maintained and kept clean. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. The provider was following national guidance in relation to COVID-19.

● At our last inspection people were at risk from the spread of infection. Rubbish had not been stored safely and securely and there was used personal protective equipment (PPE) lying around the garden. High touch areas, such as door handles and toilet flushes, had not been cleaned often and there was a lack of clinical waste bins for the disposal of PPE. Safe laundry processes were not followed and did not promote effective infection control. Some staff continued to work across two services and people had not been supported to self isolate for 14 days following hospital admissions, which increased the risk of spreading COVID-19.
● At this inspection improvement had been made. Rubbish had been cleared from the garden and used PPE disposed of appropriately. Laundry processes promoted effective infection control and we observed staff using equipment correctly. Staff working between two services were limited to the provider and one other staff member. Risk assessments were in place which utilised frequent COVID-19 testing and minimised contact with people. Revised cleaning schedules ensured high touch areas were cleaned frequently.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Action had been taken following accidents or incidents to reduce the risk of them occurring again. One staff member had offered a person a drink without thickening it and this placed the person at risk of choking. Another staff member had intervened, and the person's drink was modified to a safe consistency. The manager met with the staff member to remind them of the need to ensure they always followed Speech and Language therapist's guidelines when preparing drinks for people.
● One person had fallen and sustained an injury the day before our inspection. Action was taken shortly after our inspection to install additional handrails to reduce the risk of anyone having a similar accident.
● An analysis of accidents and incidents was completed each month. No patterns had been identified.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. 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
At our last two inspections the provider had failed to maintain 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.

Enough improvement had not been made at this inspection and the provider continued to be in breach of regulation 17.

● Since our last inspection, the provider had introduced a new electronic care recording system. Staff were required to record the care they provided, and this was detailed in people's care records. We found records had not been consistently completed and there were gaps in the records. For example, one person's care plan required staff to note the condition of their skin each day. The last record was dated 30 May 2021 and records were inconsistent before this date. Some people needed to be repositioned regularly to reduce the risk of skin damage. These position changes were recorded at night but not during the day. The provider could not be assured people were receiving their care as planned.
● Care plans were not always accurate about the support people required and their preferences. For example, one person's care plan stated they preferred to use the lift with one staff member, but staff told us the person always used the stairs alone. It also stated they required reassurance when walking around, however we observed them walking around the lounge confidently without the need for reassurance from staff. Another care plan contained contradictory information about a person's medicines. Action was required to ensure people's care plans accurately reflected their needs and preferences.

The provider had failed to maintain accurate and complete records in relation to people's care. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's statement of purpose had been changed to include details of the new manager. Other areas of the statement required updating such as details of activities on offer and the facilities. The nominated individual was unaware they were required to keep the statement of purpose up to date and notify CQC of any changes. We received a statutory notification about the change to the statement of purpose after our inspection, however it had not been fully updated and contained a number of factual

errors. This is an area for improvement.

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

● Not enough action had been taken to improve the culture of the service which did not maximise people's choice, control and independence. For example, the manager held everyone's money. When we discussed people holding their own money, the manager told us some people needed to save and would not do this if they held their own money. People had the capacity to make decisions about their finances, however they had not been supported to develop the skills in this area.

● Again, little action had been taken to encourage and support people to maintain and develop their independence. People continued not to be involved in day to day tasks at the service, such as making drinks and snacks for themselves. People, where they wished to, were not involved in household tasks such as cleaning their bedrooms or putting their clean laundry away.

● The provider's statement of purpose described how they would support people to take risks and these would be agreed with the person. We found people were not always supported to take risks and involved in how risks would be managed. For example, alcohol was restricted for one person. No risk assessment had been completed and the person had not agreed to the restriction.

● People were not always referred to in positive ways during our inspection. One relative told us they felt the provider and manager were 'judgemental' about their relative and had described them as 'difficult'. They said they felt the manager had been 'sympathetic' to the person when they began working there but now considered them 'awkward' and did not know how to meet their needs.

The provider had failed to assess, monitor and improve the quality of the service in line with nationally recognised guidance around person centred care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The culture within the staff team had improved. Staff and the management team spoke to each other and people with respect. The blame culture had been addressed and staff felt confident any shortfalls would be seen as learning opportunities. Daily ten-minute meetings enabled staff to raise any concerns and for important messages to be communicated quickly.

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

● At our last inspection, relatives told us they were unaware of changes at the service and were concerned about changes to the management team. Some relatives we spoke with following this inspection were disappointed they had not been contacted by the manager to introduce themselves. One relative told us, "I think there is a new manager." This is an area for improvement.

● Some relatives felt communication by the provider and manager could be better, especially about changes in their relative's needs. One relative told us, "The only thing they are good at communicating is when something is very urgent. In all other administrative matters, I have to ask. They don't keep in email contact. They are a closed book. It's hard to get through to them on the telephone." Others felt information about the service could be more accessible via the provider's website or social media.

● 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.

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

characteristics
At the last two inspections the provider had failed to act on feedback from people, their relatives and staff 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. However, further improvements were required to ensure the views of people and their representatives were valued and acted on to improve the service.

● A meeting had taken place since the last inspection with people who lived at the service which focused largely on gaining people's views on activities and events. People no longer chaired these meetings and this was done by the manager. People were asked whether they would like a pet at the service, suggestions included a dog, cat or fish. The manager told us most people had wanted a dog but it was decided fish were the most practical option for people to care for. They also told us some people were unhappy their choice of a dog had been dismissed. People had not been given the information they needed to make an informed decision about having a pet, including any allergies people had or how much time was required to care for the pet.
● Surveys had been completed since our last inspection to gain the views of people, staff and relatives. However, one relative told us, "I have never been asked to give feedback. I didn't form the view that me giving feedback would have a positive result". Feedback received was largely positive and recognised improvement in the service. Where relatives had made additional comments on their surveys, there was no evidence that these had been addressed or responded to. This is identified as an area that required improvement.

We recommend the provider consider current guidance in relation to gathering the views of everyone involved with the service and taking meaningful action in response to these views.

● Staff meetings enabled staff to receive more detailed information. For example, about processes within the service, concerns identified during audits and planned training and improvement required following the last inspection.
● Areas of the home had been redecorated reflecting people's preference and the CCTV system had been disabled while decorating took place. A new system had been purchased and the provider planned to consult with people and their representatives before it was installed.

Continuous learning and improving care
At our last two inspections 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. This was a continued breach of regulation 17 (Good governance) 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 17. However, further improvements are required to ensure checks and audits identify all the shortfalls at the service so they can be addressed.

● At our last inspection, people were 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. In some instances, identified

concerns had not been acted upon. Additionally, some records were not accessible or were incomplete and undated and some confidential information was not held securely.

● Audits were now up to date and complete, however they had not always identified shortfalls. For example, checks on care plans had not identified records were incomplete or contradictory in places. Other shortfalls had been identified and a service development plan had been put in place to address them. The development plan included timescales for completion and who was responsible to completing the task. For example, in relation to fire safety improvements, a review of people's emergency evacuation plans, cleaning of high touch areas, infection control and rectification of trip hazards.

● The nominated individual was actively involved in the service and completed their own checks alongside the manager's checks. This acted as a safeguard to ensure checks were effective and issues identified were addressed.

● However, while the provider had ensured tests to identify legionella risks were completed, they had not understood the full scope of their responsibility or water management policy. Regular checks on the temperature of water within the service were not completed. These are intended to ensure hot and cold water is circulated within a safe temperature range to reduce the possibility of legionella bacteria forming. This was reported to the nominated individual during the inspection as an area that required improvement.

Working in partnership with others

● One person told us at our last inspection that they no longer wished to live at the service. They told us they same thing at this inspection. We discussed this with the manager who was aware of the person's views. However, they were not able to demonstrate they had acted on the person's requests and had not discussed this with the person's social worker.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate and complete records in relation to people's care. The provider had failed to assess, monitor and improve the quality of the service in line with nationally recognised guidance around person centred care.

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.