Crown Care VI Limited

# Holyrood House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

The inspection took place on 3 and 4 February and was unannounced. Holyrood House is a purpose built 85 bed care home in Knottingley. There are several communal areas.

At the time of the inspection there was no registered manager in place, although a manager had been newly appointed and in post for three weeks and was in the process of applying for registration with the Care Quality Commission.

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 last inspection took place in April 2015 and there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent us an action plan following the previous inspection to show when the regulations would be met. However, we found continued breaches in two of these regulations at this inspection and a further five breaches in the regulations.

People and relatives considered the home was safe. Staffing levels were not always adequate to ensure people's needs were met safely, particularly at busy times and in the dementia unit.

Staff files did not always contain evidence of thorough checks and vetting to ensure staff were suitable to work with vulnerable adults.

Medicines were managed safely and people told us they got their medicines when they needed them.

Staff did not all have adequate training to meet the needs of the people, particularly in relation to people's mental capacity and dementia care.

Documentation for mental capacity assessments was not clear and was sometimes conflicting.

People enjoyed the food, although there was little choice about portion size and there was poor monitoring of people's weight and food and fluid intake.

Staff were kind, patient and caring. People and their relatives spoke highly about the staff's caring abilities.

Care records were up to date, although the information within was sometimes conflicting and some information in risk assessments was not clearly in place for staff to follow.

Activities were enjoyed by many people but care was not consistently person-centred. Some people said

they could not have a bath or a shower when they wanted to and some people who remained in bed or in their rooms said they felt bored at times.

New management was in place and although there were some systems to assess and monitor the quality of the provision, these were not robust or fully implemented to drive improvement. Audits were incomplete as were records relating to the management of the home and people's care.

The new manager showed us some examples of how the service would be more closely monitored moving forward, although these new systems were not in place at the time of the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
You can see what action we told the provider to take at the back of the full version of the 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?

**Inadequate**

The service was not safe.

Staffing levels were not always adequate to meet people's needs.

The provider was unable to demonstrate recruitment procedures were robustly carried out to ensure staff were suitable to work with vulnerable adults.

Risks to people were not sufficiently monitored to ensure their health and well being.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff were not fully supported to carry out their roles through effective training and supervision.

People's mental capacity assessments did not clearly illustrate how their rights would be protected.

People were not always given sufficient choices of meal sizes or content of their meal and there was a lack of monitoring of people's weight, food and fluid intake.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and caring in their approach and they developed good relationships with people.

Staff involved people and gave good explanations about their care and support within the daily routine.

People's dignity and privacy was respected.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

There was conflicting information in care documentation, and some information was not clear enough for staff to provide person-centred care.

There was regular engagement with the activities coordinator and activities were enjoyed by most people, although some people felt isolated whilst they remained in their rooms and said there was not enough for them to do.

Complaints were recorded, but the provider's response to these was not clear.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a new manager in post and although some areas were being identified for improvement, the systems for assessing and monitoring the quality of the provision were not robustly implemented.

There was limited oversight of practice within the home.

Records to illustrate how the service was run were not all in place.

# Holyrood House

**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 3 and 4 February 2016 and was unannounced. There were 50 people living at Holyrood House when we inspected.

There were three adult social care inspectors and a specialist professional advisor, whose specialism was in dementia care and nursing. On the first day of the inspection there was a member of the business support team who came to observe the inspection process.

We gathered information from the local authority, clinical commissioning group (CCG) and safeguarding teams prior to the inspection. We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We had received some information of concern which suggested people were not receiving safe care. We looked at notifications we had received about the service and the most recent contract monitoring information from the local authority.

We used a number of different methods to help us to understand the experiences of people who lived at the home. We communicated with 15 people who lived at the home, six relatives, the managing director, the manager, five care staff, the cook, the activities coordinator and cleaning staff.

We looked at six people's care records and five staff files, as well as maintenance records and other records relating to the management of the service. We looked around the building and saw people's bedrooms, with their permission, as well as communal areas and bathrooms.

We asked the manager to send us copies of audits carried out at the home and this was done promptly.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe. One person said: "Yes it's a safe place for me" and another said : "No worries about whether I'm safe or not, it's all alright here". People's relatives we spoke with said they felt their family members were safely cared for. One relative said their family member would not be able to manage their own safety if they lived in their own home and they had 'peace of mind' because they felt the home was safe. Another relative said the home was 'absolutely fine, perfectly safe'.

We saw the safeguarding referral log contained appropriate information which had been acted upon in line with safeguarding procedures. We saw one person who was receiving one to one care due to a number of safeguarding issues and there was good documentation showing how the staff engaged purposefully with the person during the time together.

Staff knowledge of the safeguarding procedures was inconsistent. Some staff we spoke with had not had any training and although they understood how to identify the signs of possible abuse, they were not sure what to do if a concern was raised. Other staff were aware of the different types of abuse and were confident to report any concerns internally and through the local authority safeguarding procedures.

We reviewed the available records related to accidents and incidents and saw the majority were related to falls, although it was unclear from records what action was taken to minimise the risks of falls in the home.

We noted the cleaners' trolley was left unattended on some occasions in the dementia unit, with toxic cleaning fluid accessible and no lid on the bottle. This had potential to pose a risk to vulnerable people who may mistakenly pick up the cleaning fluid.

We saw three people who were in bed with bed rails that were in use, yet there were no protective bed rail bumpers in place to ensure the people were not at risk of entrapment in the rails. We asked the nurse about the bumpers. They said they had probably gone to be cleaned. We asked if there were spares and the nurse said they 'didn't think so'. We brought this to the attention of the manager who agreed to attend to this without delay.

We looked at three care plans and found risk assessments identified that all of those residents were at high risk of developing pressure ulcers. However, the care plans were not clear on what the repositioning regime should be for each person. One stated 'regularly change position', one stated 'continue to change position' and the other one had no instruction. This meant there was no clear direction for staff to follow to ensure pressure care was managed effectively.

We looked at the repositioning charts that were kept in people's bedrooms. One chart showed the person had been positioned on their back all of the previous day and up until 9am on the day of the inspection without a change of position. Records showed two days before there had been one occasion each when the resident had been on their left and right side, otherwise always positioned on their back. We saw the person remained in bed and they were on their back during the inspection. We saw reposition charts for two other

people that recorded they remained on their back for the majority of the time. Our observations of these people in their rooms showed they were positioned on their back.

We asked the nurse on duty about the turning regimes for people who were unable to move themselves. They told us it was difficult to reposition some people and the staff would put pillows under people on alternate sides to relieve the pressure and provide 30 degree tilts. There was no evidence of this on the repositioning charts.

One of the people nursed in bed had a pressure ulcer. There was a care plan in place for this which stated it had been redressed on the 20 January 2016, two weeks prior to the inspection. This same person also had a dressing on their hand. The date was written on the dressing: 5 January 2016. This illustrated the person had not had their dressings changed regularly and we brought this to the attention of the home manager who agreed to attend to this without further delay.

There were no care plans or risk assessments for particular medical conditions, for example diabetes although there was very brief mention of this particular condition in the health care plan. The only instruction was to monitor blood glucose levels weekly but there was no reference to what would be considered normal blood glucose levels and what staff should do if their levels were not within the normal range.

The manager was unable to demonstrate how people would be safe in the event of a fire or emergency evacuation. We looked at a copy of the evacuation risk list dated 3 February 2016. It was recorded in room number but this record did not accurately include all the people in the home or their whereabouts. For example, people who were temporarily residing at the home on respite care were either not on the list or had no assigned room number. One person was listed twice, a number of other people were assigned room numbers that did not correspond to those on the room occupancy information held by the provider. Two people on the evacuation list did not appear on either the home manager's list of names or other room occupancy information.

Fire alarm, fire equipment and emergency lighting checks were implemented. The manager and maintenance staff were in the process of organising some equipment for use in the event of an emergency and this was done before the end of the inspection, with the inclusion of a fire bag containing items such as high visibility vests and torches.

We noted the staff training matrix showed the nursing staff and some care staff had not completed any fire safety training. We spoke with the managing director and home manager who told us the fire policy, risk assessments and personal emergency evacuation plans (PEEPS) were not fit for purpose. We saw the manager had developed a new policy and set of procedures which would involve using traffic light risk symbols to tag people's doors as an aide to memoire for staff in an emergency. However we noted on the action plan that the senior staff were given until the 28 February 2016 to undertake the PEEPS for people who lived at the home, which meant people may not be adequately protected should there be an emergency until these were completed. The manager had already begun to update the evacuation register before the end of the inspection and showed us documentation in progress.

The above examples illustrate the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not determine the number of staff in post. We were shown three staff lists. One staff register dated 3 February 2016 had 50 staff listed with their photograph ID and contact numbers. One list dated 3 February

2016 had staff shown by surname with 59 staff listed, their start date and contact numbers, Nursing and Midwifery Council (NMC) registration numbers and expiry date where appropriate and an active time sheet dated 4 January 2016 listed 66 staff with their grade and contracted hours. None of these lists were accurate and it was not possible to identify who was employed and where they were allocated to work in the home.

We looked at rotas for support services, kitchen staff, the residential and nursing unit and for the dementia unit. The rotas demonstrated the home was dependent on agency nurses for night shift rotas. The nursing unit also had a senior care assistant who was on the day shift rota as a supplement for the registered nurse. Similarly agency staff were deployed in the dementia unit to cover day and night shift rotas. The residential unit was less dependent on agency staff but nevertheless demonstrated some difficulties in covering night shifts and needed to deploy day staff to cover, meaning a shortfall on the day shifts on those occasions.

The newly appointed manager told us they were aiming to reduce the use of agency staff by changing staff contracts so they could be expected to cover shifts on any unit when required. We discussed this may have potential to impact upon the continuity of care.

We saw staffing levels were not adequate to meet the needs of people, particularly in the dementia unit. There were several occasions when we were concerned about people's safety and well-being because staff were not visible or close by to be able to support them. For example, one person picked up another person's box of biscuits and began to eat them. The person to whom the biscuits belonged was upset about this and we were concerned that there may be an altercation. However, we were unable to locate staff to support people for more than five minutes. On one occasion on the dementia unit there was only the unit manager and one care assistant for at least 40 minutes with 12 people who all had varying needs. The unit manager told us one care staff was temporarily absent from the unit but was due to return. We asked the unit manager whether they felt staff numbers were adequate and we pointed out our concerns about people's needs not being met. For example, we saw the lounge was left unattended and some people were becoming restless. One person asked for a drink and told staff they had been 'waiting ages' and staff told them they would have to wait until the tea trolley came, which would be about ten minutes. The person told us: "It's just not right, we shouldn't have to wait just to have a drink".

We spoke with the home manager who told us it was possibly due to the layout of the unit that staff could not support people effectively. Whilst this may have had some impact, we found there were four people who, depending on their mood had the potential to require two staff to assist them and when the two care staff were attending to one person and the unit manager was administering medication, there were no available staff to support everyone else.

At busy times, such as meal times we saw there were not always enough visible staff. For example, in the dining room we saw only one member of staff with 10 people for five minutes; yet this member of staff was designated one to one support for a person.

One person said there were frequently no staff available to take them out as they would have preferred. They said it could take 'up to 10 minutes' for staff to answer their buzzer and there was no named key worker for them to relate to.

The new manager told us staffing levels were calculated upon people's dependency needs. We found from care records and from speaking with staff that people's dependency varied, sometimes according to their mood. For example, there were four people on the dementia unit whose mobility could vary day to day. Sometimes they required full support from two staff to mobilise and at other times they could mobilise with the assistance of one staff. However, we found from staff rotas the numbers of staff on duty did not vary in

line with these fluctuations.

On the nursing unit, we were told four people needed individual support from a member of staff to assist with their meals. We saw there were only four care staff and one nurse in total on the unit, which meant those requiring one to one support to eat their meal had to wait until staff were available.

Some people, staff and relatives we spoke with told us they did not think there were always enough staff. One person said staff 'take ages' to answer their call bell. Relatives gave examples of when they had visited and found it difficult to locate staff to discuss any matters. One relative we spoke with said the unit 'could do with more staff' and told us there was often no staff visible when they came to visit if staff were attending to other people. Staff told us they tried to prioritise their time to ensure people's needs were met but said there were times when people had to wait if they were attending to others.

One relative said: "I try not to bother them [staff] as I know they're so busy". Some relatives on the residential unit said they thought there were enough staff but added their family member was independent and not reliant upon staff to support them physically. Staff told us they tried to prioritise their tasks but it was a concern when people had to wait because they were assisting others.

The above examples illustrate the provider was in continued breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not demonstrate they followed a robust recruitment process. We examined eight staff files, the majority were newly appointed staff for a range of posts within the home and found no record of Disclosure and Barring Service (DBS) checks for three members of staff all of whom were either seen or were confirmed as working at the home; one person who had declared a conviction and had not had their DBS check recorded, had also not completed a declaration of health despite being employed for over four months. We discussed the missing DBS findings with the newly appointed deputy manager who gave verbal assurances staff had been checked, although was unable to provide any evidence to support this. This demonstrated a potential risk that unsuitable people could have had unrestricted access to vulnerable people who lived at the home.

Nursing and Midwifery Council (NMC) registration numbers, although in date, were not all clearly recorded, whilst people identified on the training matrix, staff register or rotas as nurses, were either not listed, or did not have their registration number recorded on the staff list. It is a requirement of the NMC that all nurses must renew their registration annually if they wish to practice and represent themselves as a nurse in the UK.

We discussed with the new manager how the suitability and competence of agency staff was verified. We were told only reputable agencies were used, although no competency checks were carried out with agency staff to ensure they were capable of carrying out their role.

The above examples illustrate the provider was in breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed in the home. We reviewed the medicine administration records (MAR) for 15 people  They were filled in correctly apart from one missing signature and one wrong use of a code that did not exist.

There was a signature sheet in place which all the staff administering medicines had signed so it could be verified which staff member had given the medicine. We saw PRN (as required medication) protocols for

anyone taking PRN medicines.

We saw the treatment room and medicines fridge temperatures were within normal range and they were checked daily.

People we spoke with told us they received their medicine on time and staff always checked if people had any pain. One person said: "sometimes I ache a bit and they [staff] check if I need some pain killers". Another person said: I have two tablets for my pain". We heard staff spoke with people about their medicines and were patient when supporting people with this. Staff stayed with people whilst they took their medicine before recording it had been given.

One relative we spoke with said their family member was supported well to have their medicine on time. They said they considered this was one of the most important aspects of their family member's care.

Inadequate

# Is the service effective?

## Our findings

People and relatives said they felt staff had the necessary skills to do their job. One person said: "They are good at caring for me". One relative said staff understood their family member's condition and had the skills to meet their needs. They added: "If they didn't, [my family member] would move".

There was insufficient information to demonstrate new staff had been adequately prepared for their role and existing employees had undertaken relevant training.

There was no training record for any of the nurses employed at the home or evidence they had undertaken any continued professional development. We spoke with the nurse on duty on the nursing unit who had been employed at the home since May 2015. They told us they had completed e-learning on a number of topics including first aid and they were due to attend medication training and a palliative care course through the Macmillan nursing team. They said they kept up to date through nursing journals.

The dementia unit manager told us they had been given opportunities to undertake training and they demonstrated a good understanding of the needs of people living with dementia. However, we found this member of staff was leaving the organisation, although they confirmed they had been happy working at the home.

We found care staff did not always have adequate training to meet people's needs, such as in dementia care, mental capacity act and deprivation of liberty safeguards. One person who was working in the dementia unit on the day of the inspection said they did not understand how dementia affected people and had been offered no training in dementia care. Some staff told us they did not feel skilled enough to do their work. We noted that one senior care assistant most recently employed and working on the nursing unit, did not have any evidence of medication management training in their staff file.

Staff supervision records stated 'will take place at least six times per year'. We saw some evidence of effective supervision records undertaken and kept by the newly appointed deputy manager for the residential unit. However this practise was not consistent throughout the home. We found new staff in particular had not received supervision to ensure they had completed their induction and discuss their performance and development. We saw some evidence in staff files that people had appraisals, but again, this was not consistent throughout the home.

This meant the provider did not ensure people who lived at the home were supported by suitably qualified, skilled and experienced staff. The provider was in breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager told us they had already identified improvements to be made within dementia care and had plans to appoint a dementia lead member of staff to champion this work.

We saw evidence of regular head of department meetings throughout the year but regular staff meetings

with other groups of staff were not evident. For example, we saw records of only one care staff meeting which was dated 16 March 2015 and discussed personal mobile phone use on shift and infection control. We saw only one clinical meeting which discussed problems with the use of an incorrect sling, percutaneous endoscopic gastrostomy (PEG) sites management (a means of feeding where oral intake is not adequate) and unsafe staffing. We found there was one qualified staff meeting on 15 July 2015 which recorded medication management errors related to the storage, stock control of medicines including controlled drugs, administration and recording. Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines.

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 people 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
The manager understood the legislation in relation to MCA and DoLS and applications had been submitted to the local authority for DoLS. However, capacity assessments in people's care records and best interest decisions were poorly documented, not showing clear evidence of the process being followed correctly. Care plans we looked at contained information about people's mental capacity although this was conflicting. For example, one person's care plan stated 'assessed as being unable to make informed decisions that affect their life and wellbeing' but then further in the care plan it stated 'has been informed of [their] rights to withdraw [their] consent at any time'.
Managers acknowledged work was in progress with regard to assessing people's mental capacity. The unit managers were given the responsibility of implementing new documentation for mental capacity assessments and care planning but no time frame for this action had been set.

This was a continued breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about how they obtained people's consent within daily activities. Staff told us they spoke with people and offered choices, such as what to drink, where to sit and what to do. We saw this happened in practice. People were asked whether they required support with care tasks. People we spoke with said staff consulted with them about aspects of their care. One person said: "I know my own mind and staff say it's up to me how things go". Another person said: "They always ask me what I want to do, it's always my choice. If I fancy a lie in, I can do".

We observed the meal time experience for people throughout the home. We saw samples of the menus and found whilst they were in large print, they were not presented in alternative formats for people who would find it difficult to understand the written text. Dining areas were nicely set out with napkins and crockery, although they were less well presented in the dementia unit. Some people told us they liked the food. One person said: "It's first class food here". Another person said "I like the food". Another person said: "If I don't like the food I can always have biscuits or summat else". We saw snacks were readily available and there was fresh fruit and confectionary in some communal areas for people to help themselves.

We spoke with one of the cooks who told us how people's dietary needs were considered when preparing meals. They told us there was close communication with care staff to ensure people had appropriate meals in line with their needs. There had been a new chef appointed and people, staff and visitors we spoke with spoke highly of them.

We saw lunch on one day was not well balanced, for example people were offered either fish pie or fish and chips, restricting people's choice if they did not like fish. Food was presented to people already on plates with no discussion about portion size or components of the meal. The tea time meal did not appear appetising and some people said they did not want this.

One person's relatives told us they often visited at lunchtime and so were aware of the quality of the meals. They said the food was always well presented and substantial and they thought their family member's nutritional needs were met. Another relative we spoke with told us the food was of a high standard. One person's relative told us the tea time meal was not substantial enough to last until the following day. Another relative said their family member's appetite had improved since coming to the home and they told us: "Staff make sure my [family member] has eaten".

For some people there were fluid intake monitoring charts in place with desired amounts calculated individually on people's weight. However we saw the charts were not fully completed so it was difficult to judge if the optimum amount was achieved. One person's record stated they needed hourly fluids, yet when we looked at the record it had not been completed for three hours.
The recording of people's food intake was incomplete and there were a number of charts with no date recorded.

Staff told us where people were at risk of malnutrition they were weighed weekly. However, we saw one person was identified as being at high risk of malnutrition, yet had not been weighed since the 17 November 2015. The nurse told us the weighing scales had gone to be calibrated. We raised this concern with the manager who agreed to look into this further and ensure people's nutritional monitoring was addressed.

The above examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us if they needed to see a doctor the staff arranged this quickly for them. We saw evidence of other professionals' visits to people recorded in their care plans.

The premises were well decorated, furnished and presented, with plenty of resources. The building was spacious, clean and bright, with cleaning staff visible throughout the inspection. However there was a particularly strong and persistent malodour in one of the bedrooms which we brought to the attention of the manager. Seating was arranged in small group areas and we saw this enabled people to sit together sociably, to watch television or listen to music. The manager told us they were considering ways in which the environment for people living with dementia could be enhanced, to help with orientation and to ensure staff could safely assist people.

Good

# Is the service caring?

## Our findings

People and their relatives spoke highly about the staff and their caring skills. One person we spoke with said: "I feel cared for here, they've always a smile for me". Another person said: "I know they are here for me, I'm settled with that". One relative said: "The staff are lovely. I really think they care about the residents". Another relative said: "Care staff are kind people".

Relatives told us they could visit at any time and said staff made them feel welcome. Relatives said staff were mindful this was people's home.

People's rooms were personalised with their own belongings, such as photographs. We saw staff respected people's privacy by knocking on doors before entering. Staff were discreet when offering assistance with personal care.

Staff told us they took care to preserve people's dignity and we saw they ensured people were suitably covered when using the hoist and privacy was maintained when using the bathrooms. We saw staff assisted a person to adjust their clothing to maintain their dignity when they were seated in the lounge. We observed lunchtime and staff were attentive and ensured people's dignity was maintained by offering clothes protectors. People were appropriately dressed and staff had ensured they were offered help with their personal care, such as shaving and hair brushing.

We saw many caring interactions between staff and people they supported. Staff listened when people spoke with them and they made good eye contact, used appropriate gestures such as smiles and nods.

Staff demonstrated patience and kindness when they supported people and they gave explanations about the care that was offered. We saw staff enabled people to do things at their own pace without feeling rushed or hurried.

We saw people spontaneously hugged staff and staff responded with affection. On one occasion we saw staff and a person engaged in an impromptu sing song. Staff chatted to people socially and where people were unable to communicate verbally we saw staff made effective use of non verbal cues, such as smiles, friendly faces and open body language.

People's religious and cultural needs were recorded on care plans. One person said they liked to go to church and staff we spoke with told us they were aware and supportive of people's needs.

Staff communicated well with one another to ensure people's needs were met, although on some occasions we heard staff shared information with each other about people in their presence, but without including the people they were discussing.

Staff we spoke with demonstrated a sound understanding of the individual needs and personalities of the people they cared for. Staff told us they treated people in the home with the same respect and regard as

they would their own family members.

We saw people were encouraged to express their views and this was done informally and through completing questionnaires with staff.

Requires Improvement

# Is the service responsive?

## Our findings

Some people we spoke with said they felt their needs were met well at the home and staff supported them in a way that matched with their preferences for care. One person said: "They know me you see, and they know what I like. I've no complaints about the care here". One person said they could get up and go to bed when they chose. They said: "When I'm good and ready is the time I get up". One person said: "The facilities here are very good, my needs are taken care of". Another person said: "I'm happy with the care, if I press the buzzer staff come and help me out".

However, some people said they could not always have a bath or a shower when they wanted one, if other people 'were first in the queue' and there were times when they had to 'go without'. This was a particular concern raised on the residential unit. Some relatives and people reported inconsistencies in the quality of care, depending upon which staff were working. One person told us: "You never know who's on, some are better than others". Another person said: "It depends which staff are working what the care is like". One relative said: "It's different personalities I suppose, but it's not bad on the whole".

We looked at care records, which were held electronically, and found there was conflicting information with regard to people's individual care. For example, the care plan for one person stated they required two scoops of thickener in their drink to minimise the risk of choking, yet the risk assessment stated only one scoop. The care plan stated the person's food should be 'cut up into small pieces' in one section, yet 'fork mash-able' in another section. Some information was not clear or detailed enough for staff to be able to provide person centred care. For example, directions for people's mobility support were not specific and did not outline the equipment to be used or how staff should support people. Risk assessments contained conflicting information which would be confusing for staff to safely provide support. We shared these findings with the management team at feedback.

We saw the home had one activities coordinator who engaged well with people in Holyrood House. We looked at a copy of the activities planned for January and February 2016 and saw a range of events for people who lived at the home, which included exercise, dances, movies, and quiz and poetry competitions. We saw the activities coordinator spoke with people in a respectful way and encouraged them to join in with singing and a quiz. They adopted a very inclusive approach, ensuring everyone was given time and opportunities to take part in group activities.

During an exercise video the activities coordinator ensured people could see the television and hear the instructions. They understood people's needs and ensured people were ready to join in at their own pace, encouraging good participation.

We were told the newly appointed home manager had discussed the inclusion of activities for people who chose to stay in their rooms or who were confined to bed. From our observations and discussions with people who remained in bed we found there was limited meaningful activity and some people told us they were 'fed up' and had 'nothing to do'. One younger person in the service said their social needs were not well met and there was little for them to do to 'occupy their mind' except watch television or sleep. The

person said there were frequently no staff available to take them out as they would have preferred.

People and their relatives told us they 'would have no hesitation' in raising a complaint if they felt they needed to. Relatives told us they would approach any of the staff or go to the manager's office if they wished to complain. One person said: "I'd just tell them if I wasn't happy and they'd sort it I expect".

The complaints record showed that although details had been recorded, there was no clear documentation of how these had been resolved in accordance with the home's policy. The newly appointed manager did not have any information to evidence how complaints had previously been managed.

This was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

The service did not have a registered manager who was registered with the Care Quality Commission. There was a newly appointed home manager who was in their third week of post and had not yet completed their registration process with the Care Quality Commission.

People, visitors and staff reported a period of unsettled management of the home prior to the new manager's appointment. One relative said: "We don't seem to know who's in charge. We've heard there's a new one [manager] but we don't know if they'll stay". They added: "but the carers stay the same and that's a positive, there's always a familiar face". We saw the newsletter dated January 2016 had a photograph and an announcement about the new manager being in post. One member of staff told us they had worked at the home for less than a year and there had been inconsistent management throughout this time.

Staff reported feeling optimistic about the new manager's ability to run the home well. They told us the new manager was approachable and available.

We found the home was not well led or managed at the time of the inspection. Most of the senior managers at all levels within the home had recently been either newly appointed and were therefore unfamiliar with the home or they had been reassigned to new posts within the home. The home manager had been in post for less than three weeks, the deputy manager remained included in the staff rota for the unit meaning they were unable to consistently provide the new manager with the support they needed.

The newly appointed managing director had located to an office within the home and was providing some support and mentoring for the new manager, but was not always available. We found them to be generally proactive and open regarding the weaknesses within the home and they gave assurances of proposed systems to improve the quality of the service.

Whilst the managing director told us of their plans to introduce a new quality assurance system, we found there was no existing effective system to regularly assess and monitor the quality of service that people received. The new manager had begun to identify areas for improvement and we saw an action plan of some urgent care and policy issues that required attention, with evidence that these were being addressed via meetings with the heads of departments. However, we saw existing audits were neither robust nor reliable meaning the provider had no mechanism to learn from mistakes and make necessary improvements. For example, the audit information was not always consistently completed with the names of the person completing the audit nor was there always sufficient detail about the findings in order to understand what actions might be required to make improvements.

We saw an undated action plan which highlighted the provider's concerns related to a 'lack of infection control awareness'. It further identified the need for staff training and development and cleaning schedules to be followed. This conflicted with audits undertaken at the home in November 2015 on all clinical units which were recorded as 100% compliant.

Whilst infection control was an agenda item for the senior staff meeting of the 27 January 2016, the notes of that meeting only referred to the wearing of blue aprons when handling food. There were no timeframes identified for staff training to be completed, and no responsible person identified to ensure the plans were implemented.

We saw some maintenance records were in order and checks had been carried out on the lifts, moving and handling equipment, specialist beds and baths, the laundry, emergency lighting and alarms, gas and water. However, we found inconsistencies in some of the management records kept by the home. For example, for records relating to safety, staffing and regarding people who lived at the home it was not clear when and who had produced documents. Information was either out of date, misleading or incomplete, and page numbers were missing. For example in columns under 'date completed' on the service maintenance records we saw dates were either missing or had been filled in for six months ahead of time.

The above examples illustrate a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager appeared keen to tackle the challenges faced  in her role at Holyrood House. The action plan received following the previous inspection had not been fully implemented due to management changes in the home. The manager told us they would implement thorough auditing regimes and due to the short amount of time they had been in post they were still in the process of identifying where the shortfalls were.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs |
| Treatment of disease, disorder or injury | People's nutrition, hydration and weight was not effectively monitored and recorded. Regulation 14(4)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints |
| Treatment of disease, disorder or injury | The system for responding to complaints was not effective. Regulation 16(2) |

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 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | Mental capacity assessments were not sufficiently clear to ensure the rights of people who lacked the mental capacity to make decisions were respected. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider was not ensuring risks to people were mitigated in relation to pressure care, nutrition, emergency evacuation. Regulation 12(2)(a)(b) |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | How the regulation was not being met: There were ineffective and incomplete systems with which to assess, monitor and improve the quality and safety of the services provided.<br><br>There were ineffective and incomplete systems with which to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.<br>Records relating to the management of the service were not complete.<br>Regulation 17(2)(a)(b)(c) |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Robust recruitment procedures were not evident to ensure suitability of staff.<br>Regulation 19(2) |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not taken appropriate steps to ensure they had sufficient staff to meet people's needs throughout the home. |

**The enforcement action we took:**

Warning notice