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Balmoral Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Balmoral Care Home took place on 24 and 27 of June 2016. Our visit on 24 June was unannounced.

We last inspected Balmoral Care Home on 20 September 2013. At that inspection we found the service was meeting the regulations we assessed.

Balmoral Care Home is situated in the Mottram-in-Longdendale area of Tameside. The home provides care, support and accommodation for up to 32 people who require personal care without nursing.

The building is a large, detached house with an extension. The home has 32 single rooms with either washing facilities or an en-suite. Bedrooms are located over two floors and are accessible using a passenger lift or staircase. There are several communal bathrooms and toilets. The first floor has a lounge, small dining area and kitchenette. The ground floor has a separate lounge leading to the outside patio area, a large dining area, main kitchen, administration office and a quiet room. There is a steep driveway leading to the car park and the main entrance door is at the rear of the building.

At the time of our inspection 30 people were living at Balmoral Care Home.

The service had a registered manager in place. 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.

We found that although the registered manager was employed by the provider full time, they had 10 hours per week provision to carry out the role of home manager. For the remaining hours the registered manager was employed as a senior carer.

At this inspection we found breaches of six of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe storage and administration of medicines; assessing risks associated to the health and safety of people; effective recording, monitoring and analysis of accidents and incidents to prevent reoccurrence; preventing and controlling the risk of infection. Staff had not received refresher training. Best interests meetings had not been held to ensure decisions made were being made in the best interest of the person, particularly in the administration of covert medicines. People were not always treated with dignity and respect during care delivery observed during the inspection.
People were not actively involved in their care assessment and reviews. There was a lack of sufficient and effective systems in place to ensure a robust overview of the quality and safety of the services provided. Information was not stored securely and confidentially. We are considering our options in relation to enforcement for some of these breaches of the regulations and will update the section at the back of this

report once any action has been concluded.

We have made four recommendations. That the registered manager records all concerns in the complaints file. All meals, whether to specific dietary requirements or not, are served to people in the same appetising way. There is an increase in both group and individual activities for people living at the home. The registered manager to arrange to have a fire safety check.

People, their relatives and staff spoke highly of the service; one person's relative told us, "It's fantastic".

Documentation at the home showed that people received appropriate input from other health care professionals, such as dentistry and podiatry, to ensure they received the care and support they needed from community healthcare services.

The staff files we looked at showed us that safe and appropriate recruitment and selection practices had been used to ensure that suitable staff were employed to care for vulnerable people. However, we found that not all staff had received or refreshed the necessary training required to effectively carry out their role.

During this inspection we found that there were sufficient numbers of staff on each shift during the day to provide a safe and effective level of care and support to people who lived at the home. However, staff told us they had concerns around the number of care staff on the night shift.

Staff we spoke with were aware of how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm.

People had been able to personalise their own rooms and each bedroom contained information on the walls about the person and their likes and dislikes.

We found that activities throughout the home were few and we did not find evidence of personalised activities provided.

We found discrepancies and omissions with the administration of people's medicines and the storage of medication.

Our observations showed us that consent was mostly sought; however we observed instances where staff did not seek consent.

Care files we looked at, contained relevant information but we did not see evidence that people had been fully involved in deciding their own care and support needs.

During a tour of Balmoral Care Home, we saw that some areas of the home were not clean and required replacing, such as some internal doors and soft furnishings.

A full building/ environmental audit would have highlighted potential environmental risks, particularly those risks associated with infection control, as identified during this inspection.

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.

The home was not always clean and we found risks associated with infection control.

People told us they felt safe. Staff had received safeguarding training and demonstrated a good understanding of the types of abuse that people may be at risk from.

Errors were identified regarding the proper storage and safe management and administration of medicines.

Relevant risk assessments for people were not always in place.

We found that not all fire escapes were fully accessible and operational.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always asked their consent prior to care intervention and staff lacked knowledge and understanding of the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Care records and observations during the site visits showed us that people received input from other health and social care professionals, such as, district nursing, podiatry and GP.

Records produced for us showed that not all staff had received the required training necessary to provide effective care and support.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us they were well cared for at Balmoral Care Home.

We saw instances where people were treated in a caring and respectful way; however, we also saw that people were not always treated with privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw that people were not engaged in positive activity for much of the day.

People and their visitors told us they felt confident to speak with the registered manager about making a complaint.

We found that people were not actively involved in the assessment or review of their own plan of care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager worked the majority of their working hours in the care home as a senior carer. They did not have full time managerial hours to enable them to carry out all the necessary functions required by a registered manager.

The registered manager actively sought feedback from people and their relatives in order to improve the service.

People, their relatives and visiting professionals were complimentary about the home's registered manager.

Some audits were carried out periodically; however, not all areas of responsibility were covered.

Balmoral Care Home

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 24 and 27 June 2016 and day one of the inspection was unannounced. The inspection was carried out by one social care inspector.

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

We walked around the home and looked in all communal areas, bathrooms, the kitchen, store rooms, the sluice, the medication room and the laundry. We also looked in several people's bedrooms and outside the building; in the garden and patio area.

During the two days of inspection, we reviewed a variety of documents. These included policies and procedures relating to the delivery of care and the administration and management of the home and staff; including three people's individual care records and a sample of seven people's administration of medicines records.

We checked other records related to the running of a care home, including records of servicing, maintenance, training records and audit documentation.

We also inspected three staff personnel files to check for information which demonstrated safe recruitment practices and training. We looked at an additional two personnel files to check that regular supervision had taken place.

As part of the inspection process we observed how staff interacted and supported people at lunchtime and

throughout the two days of our visit in various areas of the home. We also observed one medication round. We spoke with two people who used the service, two relatives and three visiting health care professionals. We also spoke with the registered manager, the cook, the assistant cook, the laundry assistant and three carers.

Inadequate

Is the service safe?

Our findings

The relatives and visiting professionals we spoke with during our inspection all told us that they felt people were safe living at Balmoral Care Home. One relative told us, "He's safe; it's taken a weight off my shoulders." Another relative told us, "Yes, my dad is safe…there was a problem with his painkillers, but they spoke with the doctor." People we spoke with told us they felt safe living at the home, one person told us, "Staff make me feel safe, because if I fall there is always someone near."

Staff we spoke with felt that people were safe at the home and told us they felt that they had enough training and induction to enable them to safely do their job. One staff member told us, "People are safe here; I have no concerns and have never seen anything that I thought wasn't right."

Suitable arrangements were in place to help safeguard people from potential abuse. There was a safeguarding adult's policy and procedure in place and when asked, staff spoken with were fully aware of this procedure and demonstrated a good understanding of the subject. They were able to tell us about the different types of potential abuse and what steps to take to report any concerns they might have. One staff member told us that if they ever saw or heard anything that could be potential abuse they would go straight to the home manager as she was approachable. We saw evidence that staff had received training in safeguarding vulnerable adults. Staff had a good understanding of whistleblowing; this meant staff were knowledgeable around reporting concerns to the appropriate organisations if they felt that appropriate action was not being taken by management. One staff member told us, "I would always report anything."

The registered manager told us they did not use a dependency tool to determine staffing levels for the home. The home had four carers and one senior on day shifts, one carer and one senior on the night shift and one extra carer on the twilight shift between 5 and 11 pm. The registered manager and staff we spoke with felt that staffing levels were sufficient on the whole. However, when discussing the night shift staffing levels of two carers; one staff member told us, "I feel uneasy if anything goes wrong, especially in emergencies."

People and their relatives also commented on the staffing levels, one relative told us, "There are not enough staff; sometimes there's only two or three staff on during sickness or holidays." And "Staff are very busy… some people are very dependent."
During our observations throughout the inspection, we saw that staff were visible around the home and call bells were answered promptly. People who required assistance were attended to in a timely way. However, we did observe that some people had to wait a short while for assistance to eat their meals during mealtimes in the dining room. We fed this observation back to the registered manager during the inspection.

During the inspection we looked in depth at three staff personnel files to check that safe recruitment practices had been undertaken to ensure that suitable staff had been employed to care for vulnerable people. Staff files included evidence of interviews, photographic identification checks, application forms, health declarations and references. Each staff member had also had the relevant disclosure and barring

service (DBS) pre-employment check. We found one file had a second reference missing and the home manager immediately contacted the previous employer and this was resolved. This meant that the home manager had received satisfactory assurances and that robust and safe recruitment practices were followed to ensure that suitable staff had been employed to care for vulnerable people.

We looked at the way in which medicines were managed at Balmoral Care Home. We found that there was a relevant policy in place. Medication was delivered by a local pharmacy in prepared blister packs along with pre-printed medicine administration record (MAR) sheets. The home had their own 28 day system in place for the administration of medicines and this meant there was no stock carried forward, instead all surplus medicines were returned to the pharmacy. Medicines were administered by senior care staff using a lockable medicines trolley kept in the medication room. Medication administration record (MAR) sheets in individual file records documented known allergies and most had a photograph of the person to help staff identify that the right person was receiving the correct medication. However, we found that five of the MAR sheets we reviewed did not have a photograph of the person; a photograph on the front of a medication record is an important safeguarding measure to help ensure the correct medication is given to the correct person.

Medicines were administered by the senior in charge each day. The medicines are taken by the senior from the medication room to each individual person throughout the home. We observed the morning medication round on our second day of inspection and found that the senior carer who was in charge of administering the medication was also providing assistance to people in the dining room during breakfast leading to frequent interruptions. There is an increased risk of errors in medication administration when staff are frequently interrupted during the medication administration round.

We checked a sample of these records and found discrepancies in the recordings on the MARs. We found in one person's MAR sheets and blister packs that they had not received their prescribed morning medications for one day and we also found twelve extra tablets left over that could not be accounted for. Another MAR sheet and blister pack still contained the person's morning medications for one day and also had one surplus tablet that could not be explained in the recordings. This meant that people were not always receiving their medication as prescribed.
We noted that the home manager conducted monthly medication record audits, but had not previously found any significant issues or concerns with the medicine administration records.

We checked the medicine store room for security and safe temperature monitoring. We found the store was locked and contained a suitable cabinet and system for recording controlled drugs (CDs); a controlled drug is a drug whose use and distribution is tightly controlled because of its risk or abuse potential for example morphine. Medicines should be stored in a medication rooms with temperatures below 25 degrees and be monitored daily, however we found that the medicines room was not monitored for temperatures and no records were made. We looked in the specified medicines fridge, located in the medicines room, and found items that did not require storage in the fridge and should be kept at room temperature, such as, a specific cream. We also found that although there was a system in place for checking and recording fridge temperatures, this was not completed consistently and we identified several gaps where the temperature had not been checked and recorded.

Some medications are adversely affected by not being stored in line with the instructions. We identified items that had not been labelled with the date they were opened, although these items were dated by the pharmacist's label, they should also be marked with the opened date as an extra safety check to ensure their safe and appropriate administration. This is because some medications have a limited effectiveness once opened.

The above examples demonstrate a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We reviewed a sample of three people's individual care records and found that although they included a person's care and support needs, they did not include relevant risk assessments. For example, people who were in bed or a chair for most of the day could be at risk of pressure damage and would require a pressure care risk assessment. Robust and relevant individual risk assessments should be in place for each person living at Balmoral Care Home to ensure that any risks are identified and managed appropriately.

We found that in one person's care file, the one risk assessment was for moving and handling. However, this person was currently spending their whole time in bed and had specific dietary requirements due to difficulties with swallowing. We did not find appropriate risk assessments were in place for this person, for example, a nutrition risk assessment or pressure care risk assessment. We observed and checked that this person was being cared for in the required appropriate way, including the necessary nutritional support and pressure care. However, the risks associated with their care needs had not been comprehensively identified, assessed, rated for likelihood or impact, or plans put in place to manage those risks.

Another person's care plan we looked at, showed us that this person had care and support needs around continence, communication, nutrition and mobility. We observed during our two day inspection that this person was often sat down in a chair for long periods. However, we did not find the relevant assessments to address this individual person's risks, such as falling due to poor mobility or the risk of developing pressure sores due to sitting down for prolonged periods.

Individual people should have risk assessments in place that are pertinent to their specific care needs to ensure that all staff are aware of how to safely care for each person. The lack of relevant risk assessment documentation for individual people meant that risks were not identified and managed appropriately in order to protect them from potential harm.

No-one in Balmoral Care Home had a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP provides additional information on accessibility and means of escape for people with a disability and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire.

The above examples demonstrate a breach Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

As part of our inspection we looked at how accident and incidents in the home are managed. The home had an accident and incident file that contained guidance from the Health and Safety Executive (HSE), a procedure manual and a monthly monitoring form. The monitoring form recorded the incident, whether the person's risk assessment or care plan had been reviewed and a running total to show how many accidents and incidents had been recorded that month. We reviewed one month's individual accident reports and found that records were not always fully completed with all the necessary information. For example, the exact location or details of any injuries were not always recorded along with the last sheet that detailed next steps. This meant that accidents and incidents could not be accurately monitored or analysed to help prevent further instances and aid any potential investigation.

This was a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our tour of the home, we looked at how the laundry system was managed and spoke with the laundry assistant. We found the laundry room to be clean and have a safe system of operation including a clean and dirty flow through. Laundry that required cleaning was bagged and stored appropriately and clean clothes that were ready to be returned to people were hung up and looked freshly ironed. Hand washing facilities were in place and the laundry assistant was wearing the appropriate personal protective equipment (PPE) to minimise the risk of the spread of infection.

The home had two cleaners and the office held a cleaning schedule. The registered manager told us that night care staff were also responsible for completing cleaning duties. We looked around the home and found that bedrooms were clean and the home was free from any unpleasant odour. However, the rest of the home was not always clean and we found several examples of rooms, furnishings and equipment throughout the home that required cleaning or refurbishment. There were a number of doors that had dirty marks and we found that communal bathrooms were not clean and had old, rusty toilet frames bolted to the floor. Bathroom fitments and showers were old and not always clean and the curtain in the communal shower room upstairs was stained and hanging off the rail on one side. There was extensive mildew around the edge of the shower room causing it to look unclean. We brought this to the attention of the registered manager and these identified shortfalls had been rectified on the second day of our inspection.

We found in a store room upstairs that the floor was dirty with dust and debris and we could see that clean bedding was being stored in this room; some of it had spilled onto the floor causing it to come into contact with the dirty floor. We looked in the sluice room and found that it was not fully secure; being locked only with a simple catch on the outside and we found items that were accessible to people who live at the home that may pose a potential risk, for example, we found unlabelled cleaning fluids in generic spray bottles, soiled continence products, a dirty mop and there was no soap for hand washing. We found one laundry store room downstairs that had exposed pipes that were extremely hot to touch and the room was secured with a simple bolt on the outside of the door. This meant that items that could pose a potential risk were accessible to people who live at the home, some of whom live with dementia.

Throughout the toilets and bathrooms in the home we found that bins had open tops, which pose a potential infection control risk to people. We saw that other items in the home required a thorough clean, such as, one communal wheelchair which was particularly dirty with food debris and was being used to move someone from the lounge to the dining room; we brought this to the attention of the registered manager who told us it would be attended to straight away.

We visited the kitchen with the cook and looked at cleanliness and records of temperature checks and cleaning schedules. The Food Standards Agency (FSA) had carried out an inspection in November 2015 and had awarded the home four out of five stars for hygiene. We found the kitchen to be mainly clean, however, the large cooker was particularly unclean; the cook told us that this was being replaced in the next few days and this was confirmed to us by the registered manager. We looked at fridge temperature and cleaning records for the kitchen and found that these were not up to date and there were several gaps in the recordings. This meant that there was a risk that food may not be regularly stored at correct temperatures or that the kitchen was not always clean.

During the tour of the home we found a number of slings being stored in a clean laundry storeroom. We found three different sized slings in the room and identified that one of them was particularly soiled; this was taken to the laundry by a staff member to be cleaned. Staff told us that people did not have their own slings and they used whichever size they thought suitable for each person. This practice meant that there was a risk of cross infection by using the same sling for more than one person, additionally, slings are usually prescribed for one person taking into account their size, weight and disability. We observed at lunchtime on

day one that when staff were taking people from the lounge area to the dining room that required the use of the hoist; they used the same sling consecutively for three people. This meant that staff may not be using slings in a safe way and are putting people at risk of injury and cross infection.

Hand sanitiser was available throughout the home and we saw that staff had access to disposable aprons and gloves to use when carrying out personal care. However, we found serious concerns upstairs regarding infection control. We found that all hand wash dispensers were empty and there were no paper towels or wipes available. One person who lived in the home often flushed hand paper towels down the toilets and this had previously resulted in the home experiencing blocked drains. As a result of this, the home had placed notices up on bathroom and toilet doors stating that no hand towels must be accessible in these rooms. The outcome of these notices meant that people who used the communal bathrooms and toilets upstairs were not able to wash or dry their hands. This meant that people were exposed to the risks associated with poor infection control. We brought this to the immediate attention of the registered manager who arranged for this to be rectified during our visit.

The above examples demonstrate a breach Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our tour of the home we found one corridor upstairs had completely blocked the access to the fire door with a walking frame, two wheelchairs and an armchair. On another upstairs corridor we found that the break release system on the fire door was missing. We brought this to the attention of the registered manager who rectified the situations immediately. Balmoral Care Home had extended the building and provided additional bedrooms. We saw that not all the doors in the new annexe benefitted from fire door release systems.

We recommend that the registered manager arrange for the local fire service conduct a survey to check the safety of the building and fire evacuation procedures.

During the inspection, we reviewed the relevant safety documents. We saw that safety checks, such as water and fire alarm checks were carried out and general building maintenance contracts were up to date. Equipment, such as, hoisting, laundry and electrical equipment were regularly serviced. The registered manager carried out a number of audits, such as, medication audits, however, a full building audit was not carried out that would highlight any areas of concern as identified during the inspection.

Requires Improvement

Is the service effective?

Our findings

Many of the staff members had been working at Balmoral Care Home for several years and staff turnover was low. The registered manager and laundry assistant had worked at the home for 25 and 26 years respectively. This meant that people were being looked after by staff who knew them and knew each other. We saw that there was a strong and supportive staff team at Balmoral Care Home. Staff and relatives told us that the registered manager was approachable; one staff member told us they were strict but fair and said, "We have the best of both worlds…we know exactly what we have to do." And "She is approachable, supportive and I've had a lot of help and advice."

The registered manager told us they were members of a local daisy accreditation scheme. This scheme seeks to ensure that dignity standards are upheld within the service and the home has to demonstrate that they are meeting these specified standards in care delivery.

We reviewed, in depth, three care staff personnel files looking for evidence of a robust system of induction, development and a comprehensive training schedule. We reviewed an additional two personnel files when looking at supervision records. We found evidence of induction, supervisions and personal development in staff files. However, these supportive and developmental sessions were inconsistent and irregular; we saw one staff member had received supervision three times in the previous eight months and another file did not have any documentation to show supervision since 2013. The registered manager told us that this person had received supervision but they could not find the documentation. Staff we spoke with told us that they felt supported by the registered manager and benefitted from regular supervision. One staff member told us, "I have supervision every few months and find it useful…it helps to talk to someone, especially when someone passes away". Another staff member told us they had supervision sessions and found them good, "I can be honest, talk about any problems and get them resolved". This meant that staff were supported to discuss any concerns regarding staff or residents, and their own development needs.

On our request, the office administrator produced for us an up-to-date training matrix, this showed us what training staff had undergone and when refresher training was due. We saw that the majority of staff had undergone the required training for care workers, for example, first aid, moving and handling and safeguarding. However, the training matrix produced for us indicated that not all staff had received the required initial or time-dependent refresher training, for example, there were 11 staff that had either not received the training or were not up to date with their training for infection control.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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 made 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 are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Balmoral Care Home was working within the requirements of the MCA and DoLS. We found that DoLs applications had been submitted to the local authority by the registered manager for people living at the home and were awaiting approval.

We found when we spoke with staff that they did not always have an understanding of the MCA or DoLS and were not able to confidently describe to us what this meant for people who lived at the home. One staff member told us they had received some previous training whilst at college and had some knowledge in this area, for example, when asked about DoLS they were able to tell us that it could involve preventing someone from leaving the building. The training records produced for us during the inspection, showed us that staff had not received training around MCA and DoLS.

We saw in one care plan that the person did not have capacity to make decisions, however we did not see evidence of any best interests meetings. A best interests meeting, is usually held when a decision needs to be made about someone's care and where a person's lack of capacity has been established through assessment. We saw that a family member had signed documents in the person's care plan, but we did not see evidence to show us that this person had power of attorney for health and social care that would enable them to legally make decisions about this person's care.

We found in the care plans we looked at, documentation relating to people's wishes around end of life care and documents directing staff not to attempt resuscitation if needed. We found a letter from one person's general practitioner stating that the person should be given covert medication. However, we did not see evidence of a best interests meeting to discuss this action, nor did we see that this specific decision had been reviewed.

The registered manager told us of one person for whom they had held a best interests meeting with the person, their family and general practitioner around the care they would like at the end of their life. We were not able to review this evidence as the person's care files had been archived as they were no longer living at the home.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We spoke with staff about people's choices and gaining consent to provide care and support to people at Balmoral Care Home and the staff we spoke with showed a good understanding of the need to gain consent. One staff member told us how they would give people choices and another staff member told us they would always explain and gain consent from someone before providing care. They told us, "If the person cannot speak, I would look for non-verbal cues", they also told us that if the person was hard of hearing they would use visual cues and would always reassure people when carrying out care delivery. Another staff member told us that they would ask consent for everything and gave us examples, such as, asking someone if they would like to go through to the dining room to have lunch. They also told us that during their induction, the registered manager told staff they always had to ask consent from the person before any care delivery.

During our observations throughout the home, we saw many examples of staff asking consent and giving choices to people. One person told us, "I get up and go to bed whenever I want to." We saw one staff member speak kindly to one person and ask them if they would like to use the bathroom, before gently assisting them to stand and walked with them reassuring all the time. However, we did observe where people were not always asked consent. For example, we saw one instance where carers arrived in the lounge to move one person into a wheelchair to go for lunch. This person was not able to communicate due to their medical condition; however, the two carers did not ask consent or explain what they were doing. The person was manoeuvred into the sling and then raised into the air with a pump action hoist, before being placed into the wheelchair and taken into the toilet before being taken into the dining room. We did not observe staff asking for consent, explaining what was happening or providing reassurances throughout the experience. We informed the registered manager of this instance, who told us that staff know they always need to seek consent before providing care and they will be discussing this with the staff members involved.

As part of our inspection, we looked at the menus and food choices available to people living within the home. We saw that menus were varied and nutritionally balanced. Staff told us that although most meals were served at set times, they were flexible to accommodate people's own choice of mealtimes. We spoke with the cook, who told us that they would make something different for people if they did not like what was on the menu that day. We observed the cook kneeling down at eye level talking to people in the lounge discussing what they were making in the kitchen that day.

During observations it was clear that the cook was very knowledgeable around the likes and dislikes of all the people that he spoke to and there were clear established relationships evident with laughing and joking around someone's like of a particular food item. We spoke with one person about the food and they told us the food was good and said, "I like it." One relative we spoke with told us, "My dad enjoys the food."

As part of our inspection, we observed one mealtime on the first day of our visit and saw that people were offered a choice of main meal and pudding. Drinks during the meal were a choice of orange or blackcurrant cordial. There was a pleasant atmosphere during lunch and we saw friendly interactions between staff and people who lived at the home; it was evident that there were established relationships. However, we found that people who required full support with eating did not always receive assistance in a timely way and sometimes they had to wait to be assisted with their food. During this mealtime, we saw that one staff member was prompting or assisting three people to eat their meal. We fed these findings back to the registered manager during our inspection, who told us they would need to look at staffing levels during lunchtime.

We also observed one breakfast meal where we saw that people were given choices as to what they would like to eat and we observed joking between one person and the kitchen assistant regarding what they would like, "It's the usual then (name)." It was clear that staff knew people and their likes and dislikes, for example, one staff member brought out some brown sauce for one person who liked it on their bacon. People were served different meals of their choice for breakfast and one person was served tea in their china cup. Meal times were a positive experience for most people at the home. However, we did see instances where people who required assistance did not always receive their care and support in a timely way. We saw one person brought into the dining room and an apron was placed around them without comment, they were asked what they would like and this was served to them. This person required the assistance of verbal prompting with their meal, however, staff were busy and this person did not receive the assistance they required over the breakfast period. The person was prompted three times during the 25 minute observation period, on one of these occasions the staff member shouted across the dining room, "Come on (name). Wakey wakey."

During our inspection we checked to see if people were supported to maintain their nutritional and specific dietary requirements. People with certain health conditions required their food to be prepared in a specific way to ensure they could eat comfortably and safely. For example, a stage two diet means that food needs to be pureed. In addition, some people with swallowing difficulties required their drinks to be thickened with a prescribed thickening agent. We checked in people's care plans that required a special diet and checked that their nutritional needs were being met. We saw that one person had been prescribed a stage 2 diet by a nutritionist and we could see that this information was documented in the person's care plan and this information was also kept in the person's bedroom. We observed that this person was receiving their food and drink as prescribed.

We saw that people in the dining room were being assisted to eat food that had been pureed to the specific consistencies, however, the whole meal of meat, potatoes and vegetables was served all pureed together in a bowl. This meant that the food was a brown puree and these people would not be able to experience the individual tastes of each food item.

We recommend that meals for people with specific dietary requirements are served their meals in the same way as everyone else that lives at the home.

We spoke to the cook and the assistant cook about nutritional needs and preferences of the people who lived at Balmoral Care Home. They both knew that certain people were diabetic and were knowledgeable about different diet stages.

We spoke with two visiting health care professionals; one general practitioner (GP) and one district nurse. Both were complimentary about the care and support delivered at the home.

We spoke at length with one GP who explained that the home had close links with their practice and they felt that they had a good relationship and good communication with the home. The registered manager often attended meetings with the practice to discuss people's care and support needs who live at Balmoral Care Home. The GP told us that they had no concerns and felt that the home was a good home; well managed and organised. People do not often move out of the home, which the GP thought was a good sign of the care given at Balmoral Care Home.

We spoke with a visiting professional who attended the home on a regular basis. They told us that they had no issues or concerns with the home getting them out to see people when they required nursing input. The home regularly made referrals and they told us, "I have no issues or concerns." The home kept separate files in the main office for people who require input from visiting professionals, such as, district nursing visits.

Visitors told us they were welcomed into the home and were able to visit at any time. One relative told us, "There's no restrictions except mealtimes." One visiting professional told us, "I can pop in anytime". Visitors were able to spend time with people in the communal areas, their private bedroom and the accessible garden area.

Requires Improvement

Is the service caring?

Our findings

People told us they felt cared for at Balmoral Care Home. One person told us, "I'm looked after very well. The staff are very friendly." Another person told us, "Staff are very caring, they like the people."

Relatives also told us they felt their family member was well cared for, one relative told us, "Dad likes the staff, we're all happy with the care." Another relative told us, "They do a brilliant job…always reassuring my dad and work on his confidence."

During our observations, it was clear that there were established relationships between people and staff at the home. We saw several instances of laughing and joking and one person kissing the cook on the cheek. One person told us, "They do a lot to help you keep your dignity…they'd have to be paragons of virtue to be on top of things all the time."

As part of our inspection we spoke to staff and asked them how they felt about the care delivered at the home, one staff member told us, "We all work well together... we're all passionate about caring for the people." One staff member talked about the very good friendships the people had with staff, particularly the cook, and said "He goes above and beyond and really cares about the residents." They explained how they get to know each other; through reading care plans, talking and picking up cues from people around how they would like their care and support needs met and continually assessing the person. One staff member explained how they knew one person well and despite them not being able to communicate, the staff member knew the person's non-verbal cues and gave examples of actions or sounds and what they understood them to mean.

We asked staff how they ensured people maintained their privacy and were treated with dignity and respect while providing care and support. One staff member explained how they would care for someone during assistance with bathing or toileting; how they would close the curtains and cover them up whilst constantly providing reassurances and explanations. The staff member explained how receiving personal care can cause anxiety for some people and that they always provide it in the way the person prefers whilst promoting independence and prompting people to do things for themselves. Another carer told us they would always ask people and give choices, they would always be respectful and never tell someone what to do, and they ask people what they would like to wear. They told us, "I love my job, I love being with the residents…it's very challenging and rewarding…it's different every day."

We received positive feedback from staff and relatives around how caring the registered manager was, one staff member told us, "They are very good with residents, they have a lovely way with them." We observed the registered manager who was assisting someone with their meal whilst in bed; they explained what they were doing and spoke with the person kindly throughout whilst knelt at the side of the person's bed so they were at eye level. The registered manager maintained eye contact and gave the person their full attention whilst responding to cues for more food or drink. One person we spoke with told us, "The manager is very good…they are approachable."

One visiting therapist told us that they felt there was a homely feel to the place and said, "There's a nice atmosphere."

We observed that people were mainly given choices throughout out visit and we observed some lovely, caring interactions. We saw people being encouraged and talked with kindly whilst being given choices. Staff were attentive and noticed when someone required assistance. We observed people being assisted to eat whilst being spoken to kindly and given time to eat their food. We saw staff hold people's hand and put a reassuring arm around them whilst helping them to walk.

However, we also saw instances where one staff member referred to people who required assistance with their meal as "The feeders" and we observed one staff member shouting very loudly in someone's ear, who was hard of hearing, whilst sat in the lounge asking if they wanted to use the toilet. We were also shouted at across the full dining room when a senior carer wanted to let us know about someone's medication administration, "I'm putting them in his mouth because he doesn't have the ability to do it himself." During the lunchtime observation, we saw that one staff member approached a person from behind and placed an apron around their neck without warning; the apron was soiled with dried food. We drew this to the attention of the staff member who replaced it with a clean one.

We informed the registered manager of one incident where one person was being hoisted. Staff tried to lift one person out of their chair and when this was unsuccessful; staff did not talk to the person but spoke to each other over the person deciding how to get them up. The staff decided to get the hoist and proceeded to hoist the person without consent, explanation or reassurance. This person was left suspended in the hoist for several minutes whilst one carer went to find a pressure cushion for a wheelchair. The person was placed in the wheelchair and one staff member told the other, "Put them on the top table." This meant that this person was not given choices or treated with dignity during this interaction. We later checked this person's care plan and found that this person could not hear and the registered manager told us that their preferred choice of communication was through writing things down on paper. We also saw that there was no documentation to say that this person had been assessed to use the lifting hoist. We informed the registered manager who told us that they would speak to the staff concerned immediately.

The above examples demonstrate a breach of Regulation 10 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect

Two people who lived at Balmoral Care Home were married and the home had gone to lengths to accommodate their care needs and preferences. At their request, the registered manager had turned one bedroom into a double room and another bedroom into a separate living room for both of them. Both rooms had their personal belongings and furniture brought from their own home. We also saw that each mealtime they sat together on a table for two and used their own cutlery and had their juice served in wine glasses. This showed us that the registered manager respected people's preferences and choices and had accommodated them.

Requires Improvement

Is the service responsive?

Our findings

We reviewed three people's care plans and found they included important information on how to support each person and we saw that they were reviewed regularly. We could see information included from professionals, such as, the speech and language therapy (SALT) team and the district nurses. Care plans also included a daily report sheet that contained information, such as, how they had slept or what they had eaten that day. However, they were disorganised, not in chronological order and included old information or information that was not required to effectively provide care to the person, for example, the home's terms and conditions. In one care plan we saw a daily living assessment from 2011 and a monthly observation chart that had ceased in 2015. Another care plan we looked at, had loose pages at the front of the file and dates were missing on some of the enclosed documents.

We found in each of the care plans a "personal centred plan of care" that gave the carers a snapshot of the person's care needs, for example, communication, mobility, vision, sleep and mood. This was a useful tool for care staff, particularly new staff as it provided a quick summary of each person's care and support needs.

This plan also included a very short section on "family consideration" and "history of life events"; this gave information on immediate family and was useful for staff to know the background of the person. We did not find in the care plans we reviewed; information on what the person's preferences were, likes and dislikes or what they like to do for pastimes or enjoyment. We did not find evidence in the files we looked at of any activities people had taken part in or where people had been supported to follow their own interests, such as, particular books they like or being supported to carry out an activity.

When we spoke to the registered manager, they acknowledged that care plans needed to include more up to date, relevant and personal information. The registered manager told us that people did receive care and support that reflected current care needs because the staff knew the care needs of the people well. However, we did not see evidence in the care files that people had been involved in writing or reviewing their care plan and we did not see where people's preferences, choices had been incorporated into the plans. Care plans reviews were signed by staff and we did not see any documentation to show us that the person or their representative had been involved in their plan of care.

This was a breach of Regulation 9 () (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We looked at how people's current care needs were communicated to and between staff. People's care plans included daily recording sheets that showed what their care and support needs had been that day and night. The main office held a "communication book", which included information such as, who had been seen by the doctor that day or who had been to an appointment. We also looked at the handover sheets between seniors on shift each day, their effectiveness was variable as we found that some sheets contained relevant and detailed information about people and others had minimal detail. The night care handover sheets that we reviewed were particularly scant and did not include sufficient information about people to

effectively ensure that the next shift knew the current care needs of people. One staff member told us, "Sometimes the communication is a bit off…staff should concentrate more and give more information at handover." We brought these shortfalls in the recorded information to the attention of the registered manager, who told us they would speak to the staff members who had not filled in the handover sheets fully to make them aware of the importance of this detailed information.

We looked in several bedrooms and found that rooms showed a high level of personalisation, one person had been a school teacher before their retirement and had their school name plate put on their room door. Other people had placed photographs and cards on their walls and people mainly used their own bedding sets. Rooms we looked in were clean and tidy and free from odours.

The home did not employ an activities co-ordinator, but one staff member provided a craft session on Monday afternoons, which was very popular with people; on the day of our inspection there were ten participants. We saw that there was a notice board on the wall in the corridor displaying what activities were on that month; this was a small programme and included the Monday craft session and a visit from the hairdresser once per week.

During our inspection we saw that a holistic therapist was visiting a number of people and providing a paid service to massage hands or feet. The home also arranged for a chiropodist to visit regularly to provide foot care.

The registered manager told us that two members of a local church attended each week to visit people and play cards. Also from the same local church, someone came to collect a small number of people each Monday to take them back to the church hall to watch films. The registered manager told us that during August they would be welcoming some young people into the home from a volunteer scheme called "Challenge18", where it was hoped that they would provide some activities with the people.

One visitor, whom we spoke with, told us that they did not think there was enough activities for their relative, although it had improved, they told us, "There's no trips out…they don't do anything." We also spoke with staff who told us, "Trips would be good…but there's transport issues. Sometimes a singer comes in." We asked about one to one, personalised activities and the staff member told us that they cut people's nails. Another staff member told us, "We definitely need more activities…there's not enough stimulation."

We recommend that Balmoral Care Home provide more activities, both group and personal, for people living at the home to improve stimulation and provide personalised care and support.

As part of our inspection, we looked at how the home actively sought and acted on feedback from people who use the service and their relatives. We saw that a quality assurance survey had been sent out very recently and a small number of replies had been received, all of which had positive responses. We reviewed documentation around a satisfaction survey completed in 2015; people were asked their opinions on aspects of the home, such as, what people think of the care and how things could be improved. Comments received back included, "Staff communicate well", Homely" and "Staff are excellent". We asked the registered manager to show us evidence of what changes had been made in response to the feedback from the 2015 survey, they told us that one of the issues raised had been the need for new lounge chairs and these had now been purchased. However, the registered manager could not locate the analysis and outcome document at the time of our inspection.

Information on how to make a complaint was displayed in the reception area of the home, including the details of other agencies to complain to if not satisfied. Additionally, this complaints information was

included in the resident handbook. We saw that there was a complaints policy and a complaints record file. However, nothing had been written in these records for some time; the registered manager told us they had not had a complaint since the last record, but they had received concerns that had not been recorded. The registered manager told us that they had an open door and any concerns raised by people or their relatives had been resolved and actioned at the time and therefore removing the need for formal complaints. We spoke with people and they told us that they would feel comfortable to approach the manager to make a complaint, one relative told us, "I have no complaints, but I would feel happy to complain…everyone is approachable." Another visitor told us they had previously complained regarding ensuring that staff put cream on their relative's legs and this had been resolved straight away. We discussed with the registered manager the need to record all complaints whether considered to be more formal or minor concerns.

We recommend that the registered manager ensures that all concerns are recorded in the complaints file including details of the outcome.

Requires Improvement

Is the service well-led?

Our findings

The home had a manager in post that had been registered with the Care Quality Commission (CQC) since February 2011 at this location.

Part of a registered manager's responsibility under their registration with the Care Quality Commission is to have regard to, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. When asked, the registered manager had not accessed the relevant guidance on meeting the regulations.

We met with the providers of the care home who were visiting during the inspection and they stayed during the first day of inspection in case we had any questions we needed to ask them.

We found when talking with the registered manager, that this was not their full time role and they did not have a deputy manager. The registered manager told us that they had been allocated 10 hours per week to spend on the role of registered manager and the other hours were spent within the role of senior carer. During the first day of the inspection we found that we had limited access to the registered manager to be able to ask questions around their role and the day to day running of Balmoral Care Home. The building tour was conducted by the inspector and a care assistant because the registered manager was on senior care duty that morning and was administering the medication round to people. The registered manager came into the home on their day off to attend to our questions during the second day of our inspection. The home had a part-time office administrator who also worked part-time as a senior carer. The registered manager and provider are responsible for ensuring the regulations associated with their registration with the CQC. This meant that the registered manager was required to ensure adherence to the regulations and manage the care home in their allocated 10 hours per week.

As part of our inspection, we reviewed documentation regarding systems used by the registered manager to check the quality and safety of the building and its associated systems. There was a record of premises, equipment and maintenance checks, such as, electrical installation, lift servicing, clinical waste, lifting equipment and electrical testing of equipment (PAT). We saw that these important checks and maintenance were in place and up to date.

The registered manager told us they periodically carried out night-time inspections, where they would come to the home during the night to check that good care and support was being delivered at all times of the day and night. However, these checks were not formally recorded.

It was evident that the registered manager valued highly the feedback from people and their relatives about their views and experiences of living at Balmoral Care Home. We saw evidence in a number of areas where people's opinions had been used and incorporated into how the service was run.

The provider did not have sufficient and effective systems in place and in use, to regularly assess and monitor the quality of service that people received. We found that no formal competency checks were

carried out on staff by the registered manager. Reviews of documentation and observations made showed us that audits and checks were not always fully completed. For example, there was no infection control or mattress audit carried out. We found issues with the general environment as documented earlier in the report that would have been highlighted with a full environmental audit. For example, the soiled bathrooms and wheelchair. This meant that a regular and robust auditing system was not in place or being implemented and the registered manager and registered provider did not operate effective systems to monitor the safety, quality and risk of services to people within the home.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Personal information around people who lived at the home was not kept confidential and systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plans, was not secured away but was kept on an open shelf in the reception office. The reception office door was held open with a magnetic catch and we observed several occasions where the reception office was unmanned. This meant that this private information not kept secure was accessible to people and visitors to the home.

This was a breach of Regulation 17 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Staff felt supported in their role and we received comments, such as, "The manager is supportive, they've given me a lot of help and advice." And "I feel supported, if I have a problem I can go to the manager."

People, relatives and visiting professionals all told us they were happy with the way the home was run and were complimentary about the registered manager. People and their relatives felt that they could approach the manager and action would be taken. Visitors told us they were kept informed about their relative's care and one person told us whilst laughing, "Quite often my family can tell me what's going on before I know it myself."

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 People were not actively involved in their care assessment and reviews.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect during care delivery during the inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interests meetings were not held for people who did not have capacity to make decisions about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient and effective systems in place to ensure a robust overview of the quality and safety of the services provided. The provider did not ensure the security and confidentiality of information relevant to carrying out the regulated activity and did not adhere to the Data Protection Act 1998.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not being cared for by staff who had received or refreshed the requisite training to effectively carry out their duties.

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 We found that people's medication records showed they had not always received their medicines in a safe way. Medicines were not stored safely. People did not have risk assessments in place that were specific to their needs. People were not protected from risks associated with cross infection due to poor infection control practices. We found that the provider was not meeting the legal requirements of the Regulation 12, (1) (2), Safe care and treatment, of The Health and Social Care Act 2008.

The enforcement action we took:

We have issued a warning notice to the provider to become compliant with the regulation by 31 August 2016.