Crown Care IV Limited

The Royal

Inspection report

Queen Marys Road
New Rossington
Doncaster
South Yorkshire
DN11 0SN

Tel: 01302863764
Website: www.crowncaregroup.co.uk

Date of inspection visit:
31 May 2016

Date of publication:
27 June 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 31 May 2016, which meant no one related to the home knew we would be inspecting the service. The care home was registered with the CQC under a new legal entity [the name of the company operating the home] in February 2016 so this was the first inspection of the service under the new registration.

The Royal Care Home is situated in Rossington on the outskirts of Doncaster. The service is registered to provide both nursing and personal care for up to 57 people in the categories of older people, mental health, younger people and people living with dementia. At the time of the inspection 33 people were living at the home.

The service did not have a registered manager in post at the time of our inspection. However, a manager had been appointed and had been in post for approximately six months. They were in the process of registering with the 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 and associated Regulations about how the service is run.

People who used the service, and the visitors we spoke with, told us they were happy with how care and support was provided at the home. They spoke positively about the staff and the way the home was managed. One relative told us, "The new manager is excellent. The home has turned around." Another relative described the home as, "The best it's been."

People told us they felt safe living and working at the home. We saw there were systems in place to protect people from the risk of harm. Staff we spoke with were knowledgeable about safeguarding people and were able to explain the procedures to follow should an allegation of abuse be made. Assessments identified any potential risks to people and we found care plans were in place to ensure people's safety.

Medicines were stored appropriately and procedures were in place to ensure they were administered safely.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However, care records did not always clearly record decisions made in people's best interest.

There was enough skilled and experienced staff on duty to meet people's needs, but some relatives felt additional staff would be beneficial at key times, such in the morning and at lunchtime.

There was a recruitment system in place that helped the employer make safer recruitment decisions when employing new staff. New staff had received an induction into how the home operated and their job role, at

the beginning of their employment. They had access to a varied training programme that met the needs of the people using the service.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. The people we spoke with said they were happy with the meals provided and we saw they were involved in choosing what they wanted to eat. On the day we visited the dining rooms were relaxed and people who used the service were given time to eat their meal leisurely.

People's needs had been assessed before they went to stay at the home and we found they, and/or their relatives, had been involved in the planning their care. The care files we checked reflected people's needs and preferences, so staff had clear guidance on how to care for them.

People had access to a programme of activities which provided regular in-house stimulation, as well as trips out into the community. Relatives told us people enjoyed the activities they took part in.

We saw the complaints policy was available to people using and visiting the service. The people we spoke with said they had no complaints, but said they would feel comfortable speaking to staff if they had any concerns. We saw when concerns had been raised they had been investigated and resolved in a timely manner.

There were effective systems in place to monitor and improve the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us the home was a safe place to live and work. Staff had received information and training about how to recognise signs of potential abuse, and were aware of reporting procedures. Assessments identified risks to people and plans were in place to manage any identified risks.

Recruitment processes were thorough which helped the employer make safer recruitment decisions when employing new staff. Overall there was sufficient staff on duty to meet people's needs.

Systems were in place to make sure people received their medications safely, which included key staff receiving medication training.

Is the service effective?

Good

The service was effective.

Staff had completed training in the Mental Capacity Act and understood how to support people whilst considering their best interest. However, care records did not always fully incorporate information about decisions made in people's best interest.

A structured induction and training programme was available which enabled staff to meet the needs of the people they supported.

People received a well-balanced diet that offered variety and choice. The people we spoke with said they were happy with the meals provided.

Is the service caring?

Good

The service was caring.

People were treated with respect, kindness and compassion. They told us staff were always welcoming, helpful and caring. Staff demonstrated a good understanding of how to respect

people's preferences and ensure their privacy and dignity was maintained.

We observed that staff took account of people's individual needs and preferences while supporting them.

Is the service responsive?

Good

The service was responsive.

People had been encouraged to be involved in care assessments and the planning of their care. Care plans reflected people's needs and preferences.

People had access to various activities and outings into the community, which they enjoyed.

There was a system in place to tell people how to make a complaint and how it would be managed. People told us they would feel comfortable raising any concerns with the management team.

Is the service well-led?

Good

The service was well led.

People we spoke with told us the new manager was approachable, always ready to listen to what they wanted to say, and acted promptly to address any concerns.

There were systems in place to assess if the home was operating correctly and people were satisfied with the service provided. This included meetings and regular audits. Action plans had been put in place to address any areas that needed improving.

Staff were clear about their roles and responsibilities and had access to policies and procedures to inform and guide them.

The Royal

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 was 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.

The inspection took place on 31 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before our inspection, we reviewed all the information we held about the home. We also asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We contacted the local authority and Healthwatch Doncaster, to gain further information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of the visit there were 33 people using the service. Most people were living with dementia so we could not speak with them in a meaningful way. However we spoke with seven people who used the service and six visitors. We also spent time observing how staff interacted with, and gave support to people. We used the Short Observational Framework for Inspection (SOFI) in one of the dining rooms at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the acting manager, a nurse, the residential unit manager, five care workers, the cook and the activities coordinator. We also spoke briefly with the regional director who visited the home near the end of the inspection.

We looked at documentation relating to people who used the service and staff, as well as the management of the service. This included reviewing five people's care records, the training matrix, six staff recruitment and support files, medication records, audits, policies and procedures.

Good

Is the service safe?

Our findings

People we spoke with said they felt the home was a safe place to live and work, and our observations confirmed this. For instance, one relative told us, "It's such a relief to know that [my relative] is safe, secure and well looked after."

We saw care was planned and delivered in a way that promoted people's safety and welfare. Records were in place to monitor any specific areas where people were more at risk, and explained to staff what action they needed to take to protect them. We saw assessments covered topics such as risk of falls, poor nutrition and moving and handling people safely. We also found equipment such as specialist beds, bed side safety rails and pressure relieving equipment was used if assessments determined these were needed.

Staff we spoke with demonstrated a good understanding of people's needs and how to keep people safe. They told us how they encouraged people to stay as mobile as possible while monitoring their safety. We saw most people were mobile with, or without, assistance from staff, but where assistance was required this was carried out in a safe way. We also found staff had received training in how to move people safely.

We also saw there were appropriate arrangements in place in case the building needed to be evacuated, with each person having their own evacuation plan.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The manager and the staff we spoke with understood their responsibilities in promptly reporting concerns and taking action to keep people safe. They could identify the types and signs of abuse and told us they had received training in this subject. This was confirmed in the training records we sampled.

We found that overall there was enough staff to meet the needs of the people being cared for at the time of our inspection. Most people we spoke with confirmed there was enough staff available to meet people's individual needs. One person's relative told us, "Staff are deployed in a better, more structured way, which meets people's needs more effectively. As soon as someone needs care, staff are there straight away, and this is better for people's dignity."

Relatives told us call bells we answered promptly and people received care in a timely manner. During our visit we found this was the case. However, two relatives felt an additional care worker at busy times, such as in the morning and at lunchtime, would be beneficial. One relative commented, "Another body [staff member] would be useful as a lot of people need two staff [to provide care]."

Staff we spoke with agreed there was enough staff on duty to meet people's needs and that they were deployed effectively. For instance, one member of staff told us that on the residential unit there were three staff supporting 18 people, which they felt was sufficient to meet the needs of the people they were supporting.

We found a satisfactory recruitment and selection process was in place, which included new staff receiving a structured induction to the home. We sampled four recently recruited staff files which contained all the essential pre-employment checks required. This included written references, and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We found the professional qualifications of nursing staff had also been checked to ensure they were registered to work as a nurse. A recently recruited care worker we spoke with described their recruitment experience, which reflected the company policy.

We looked at the arrangements in place for the management and administration of people's medicines and found that these were appropriate. Medicines were only handled by members of staff who had received appropriate training. These staff were also subject to on-going observational competency assessments to ensure they were following company polices.

We spoke with an agency nurse and a senior care worker about the medicines procedures and practice in the home. We also observed them giving people their medicines. We saw they followed safe practices and treated people respectfully. They explained things to people while providing the appropriate support they needed to take their medicines.

People's care records included details of the medicines they were prescribed, any side effects, and how they should be supported in relation to their medicines. Where people were prescribed medicines to be taken on an "as required" [PRN] basis, protocols were in place for each person to guide staff as to how and when to administer these. We saw the amount of variable dose PRN medicines had been routinely recorded to reflect what staff had given to people.

The agency nurse told us that the information available about the medicines prescribed to people, and the way they liked to take their medicines was clear and enabled them to administer people's medicines safely. They also said that although people's photographs were part of their medicines profiles, they were cautious and checked people's names with the care staff to ensure they gave the right medicines to the right person.

People's medicines were stored securely, with additional storage for medicines controlled under the Misuse of Drugs legislation, referred to as 'controlled drugs' [CDs]. We checked records of administration and saw that the medication administration records [MAR] were completed appropriately. There were systems in place for stock checking medicines, and for keeping records of medicines which had been destroyed or returned to the pharmacy. We saw that audits were undertaken by a member of the management team, and any issues identified were followed up, with records of action taken.

The temperatures of the rooms where medicines were stored and refrigerator temperatures were monitored. We found temperatures had been recorded daily. However, only the current temperature had been recorded rather than the maximum and minimum, as recommended in the most recent national guidance. The recorded temperatures we checked were within the recommended range.

Good

Is the service effective?

Our findings

People we spoke with said staff were caring, friendly and efficient at their job. One relative told us, "They [staff] are lovely." Another relative said, "The staff are fantastic and the care is very good."

We found that overall staff had the right skills, knowledge and experience to meet people's needs. The management team told us all new staff had, or were, completing the company's mandatory training, which included moving people safely, health and safety, food safety and safeguarding vulnerable people from abuse. The staff we spoke with confirmed they had undertaken an induction when they started to work at the home, which included shadowing experienced staff. One staff member said they felt their induction could have been better, however they added that they thought the induction process had improved since the new manager had been appointed.

The manager was aware of the new care certificate introduced by Skills for Care. They said all appropriate candidates employed would be expected to undertake this award. The Care Certificate looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

There was a computerised training matrix to monitor which training staff had completed and when it required updating. It showed that most staff had completed essential training such as dignity and respect, fire safety, dementia awareness and nutrition. Staff said they had received all the training they felt they needed. One care worker told us, "It's good training now [indicating that in the past this had not always been the case]." Another staff member said, "I have had all the training I need." Two staff told us they preferred face to face training rather than e-learning on the computer, as it gave them the opportunity to ask questions. We saw the manager had identified this on staff support records. The manager and regional director told us e-learning was to be phased out and replaced by more face to face training.

Records showed that since the new manager was appointed staff had received regular supervision sessions. The manager told us that as the management team was now in place all staff would receive an annual appraisal of their work performance. As the manager is not a registered nurse arrangement had been made for nursing staff to receive clinical support from one of the deputy managers. The manager said the company had also produced a pack to support nurses to maintain their register qualification with the Nursing and Midwifery council [NMC].

Staff we spoke with said they felt well supported and confirmed they received regular support sessions as well as staff meetings. One staff member commented, "I have supervision every couple of months." Another person commented, "There is a matrix on the wall in the office so we know when our supervision is due. You can talk about whatever you want to." They went on to say, "You can talk to any of the senior management at any time they are totally approachable."

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who

might not be able to make informed decisions on their own and protect their rights. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom. Staff comments and training records demonstrated that they had received training in these subjects. We saw applications had been made to the DoLS supervisory body. Three applications had been approved, and the manager said they were waiting for the outcomes of other applications.

Records sampled demonstrated that where people could not speak for themselves decisions had been made in their best interest. However, care records did not always fully incorporate information about decisions made in people's best interest. For example, some people had bedrails in place for their safety. Assessments for their use had been completed, which were signed by the nurse who had completed the assessment. However, there was no record on people's files of how the best interest decisions had been reached to support their use. Additionally, one person sometimes had their medicines administered covertly, in food. There was a record of the GP agreement with this. However, the person's records did not reflect the best interest process followed. We discussed these shortfalls with the manager who said they would ensure all best interest decisions were recorded in a more consistent way throughout people's care files.

We observed lunch being served in both dining rooms and spoke to people before and after the meal. Dining rooms had a relaxed atmosphere and staff provided the support people needed to eat their meals in an unhurried and sensitive way. The menus were displayed on large boards. The manager told us menus had been recently changed and they were in the process of laminating pictures of the meals. This was so staff could show them to the people who needed support, to help them to choose the meal they wanted and to help them to communicate their preferred meal. Staff told us that in the meantime they would plate up each option, so people could select the one they preferred. We saw some people preferred to eat their meal in their room or in the lounge areas, and staff respected their decisions.

People we spoke with said they had enjoyed their lunchtime meal. Relatives told us they felt the meals provided met their family member's needs. One relative said, "The meals are nice and portions sizes are good." Most relatives we spoke with mentioned that the food had improved since the new manager had come into post. One person's relative said, "The quality of the food is much better. Now, it's food that I would want to eat." Another person also commented, "The food has improved."

We saw drinks and snacks were available between meals and staff said snacks were available 24 hours a day, for instance if people wanted something to eat during the night.

The cook demonstrated a satisfactory knowledge about catering for people's medical and cultural dietary needs, as well as their preferences. However, they said they had not received any formal training in relation to these topics. They did however say that all the kitchen staff were enrolled on a nationally recognised course relating to their job roles. We discussed the lack of specialist training with the manager so they could look at any additional training the cooks may need to undertake.

Staff, and the relatives we spoke with, told us how health professionals such as GPs and dieticians could be involved if there were any concerns about meeting people's dietary needs. People who were at risk of poor nutrition or dehydration had a nutritional screening tool in place which indicated the level of risk. Care plans were in place to guide staff regarding supporting people to eat and drink enough. Where needed, monitoring charts had been used to record and assess people's food and fluid intake. A care worker told us,

"If someone isn't eating I look at their care plan for the food they like and give it for them. If I still had concerns I would take it to the senior carer as there could be some underlying issues."

People were supported to maintain good health and had access to healthcare services. Care records detailed any health care professionals involved in the person's care, such as doctors, district nurses, chiropodists and opticians. The manager told us how they were also forging links with the local doctor's surgeries to improve the system for reviewing and ordering medication for people.

Good

Is the service caring?

Our findings

Our observations, and people's comments, indicated that staff respected people's decisions and confirmed they, or their relatives, had been involved in planning the care staff provided. One person we spoke with told us, "I talk to the staff regularly and the manager always has time for you." Another relative commented, "[My relative] isn't interested in doing a lot of the things that they used to, but the staff are very skilled at getting them to do things that they will do. That's a real skill and they [the staff] are brilliant at it." A third visitor told us there were two male staff who were very good at engaging people and lifting their mood. They said, "It is the way they talk to people and make use of humour. They get people really laughing and joining in the banter."

Some people were living with dementia and unable to speak with us, due to their complex needs; therefore we spent time observing the interactions between staff and people who used the service. We saw staff were kind, patient and respectful to people, and people seemed relaxed in their company. We saw staff communicated with, and treated people in a caring manner. Where necessary they spoke with people in a discreet, quiet and calm manner. They listened to people, making eye contact and waiting patiently for answers.

We saw staff supporting people in a responsive way while assisting them to go about their daily lives. They treated each person as an individual and involved them in making decisions. People were offered choice and supported by helpful staff. For instance, we saw people chose where they spent their time, with some people choosing to stay in their rooms while others sat in communal areas, and staff respected these decisions. A relative told us, "Certain staff go the extra mile by coming in on their days off to volunteer to take people out on trips."

We found people's needs and preferences were recorded in their care records. For instance, whether the person preferred a male or female care worker to deliver personal care and what time they normally liked to get up and go to bed. Staff were able to describe the ways in which they got to know people such as talking to them and reading their care files, which included information about people's likes, dislikes and history.

Staff described to us how they preserved people's privacy and dignity by knocking on bedroom doors before entering, closing doors and curtains while providing personal care and speaking to people about things quietly, so they could not be overheard. A care worker told us, "We do things like using people's initials when speaking about them to keep confidentiality."

People living at the home looked well-presented and cared for and we saw staff treated them with dignity. The relatives we spoke said they felt their family member's dignity and privacy was respected by staff. However, two relatives spoke negatively about the safety gates on some people's rooms being removed. One person said the manager had ensured they had a key so they could lock the door when their family member was not in the room, but worried about people walking in when they were there. We discussed this with the manager who explained the gates had been removed for safety reasons. For instance, the doors would not close in a fire.

Relatives we spoke with said they could visit without restriction. We saw visitors freely coming and going as they wanted during our inspection. One relative told us, "We can visit anytime. We often come in the evenings and we see the night staff. They are very caring and considerate in the way they treat people." They added. "I have often sat and listened, when the staff were not aware that I was there, and they always treat people the same way."

Good

Is the service responsive?

Our findings

Relatives we spoke with indicated they were happy with the care and support provided to their family member. One person who lived at The Royal told us, "I love it here." A relative said, "Nothing is too much trouble for them [staff]." Another relative described how staff had, and were, supporting them and their family member following deterioration in their health. They said the staff could not have been more helpful and supportive. A third person told us that the staff were more flexible and responsive to people's needs since the new manager came into post. They said, "It's the little touches. The other day I came in and [my relative] was eating a 'Cornetto'. That was lovely. They [staff] are going outside with people more."

We saw interactions between staff and people using the service was good and focused on the individual needs and preferences of the person being supported. Care workers offered people options about their meal or where to sit and responded to their requests promptly.

The care records we sampled showed needs assessments had been carried out before people were admitted to the home, and this was confirmed by the relatives we spoke with. They also said they, and their family member if possible, had been involved in the assessment and care planning process.

The home mainly used computerised care records, but some paper records were maintained. The records we sampled contained detailed information about the care and support the person needed, along with information about how staff could minimise any identified risks. This information included the person's abilities, so staff knew the level of support needed and could therefore enable the person to maintain their independence. We also found there was clear guidance on how people could communicate their wishes. For instance, one plan said the person could communicate their choices via limited communication, gestures and blinking their eyes. This meant staff could ask them what they wanted and respond accordingly.

Various assessments were in place to minimise risks, such as falls, moving people safely and behaviour that could challenge other people. We saw where potential risks had been highlighted care plans reflected the areas of risk and told staff how they could minimise these risks. For example, one plan highlighted the triggers that may cause someone to become upset, what this would look like, and provided staff with guidance about what actions they should take to support the person. Care plans and risk assessments had been reviewed each month to evaluate their effectiveness and had been updated as necessary. We also saw daily notes outlined how the person had spent their day and any changes in their wellbeing.

The home employed an activities co-ordinator who arranged social activities and stimulation within the home and out in the community. They told us they consulted with people to see what they liked to do and read their care plan to find out about past interests. The activities co-ordinator described how they spent one to one time with people reading or talking with them, as well as organising group activities. They said household jobs had also been added to the activity programme, such as folding laundry, which they said people enjoyed.

Activities for the week were displayed in the reception area. These included, pampering sessions, a 'gents

afternoon', a church service, armchair exercises, bowling, a gardening club and visits into the community, such as to the local market. The manager showed us the 'Café' which had been developed on the first floor to enable relatives to sit with their family member and have a drink or snack.

People living at the home said they enjoyed the activities they took part in, such as bingo and sing-alongs. Staff told us about certain people being enabled to follow past hobbies. For instance, staff supported one person to go to cricket matches. A relative told us, "They [activities] are very good, but there seems to be more going on upstairs than down. She [family member] likes music and chatting." Another relative said, "The activities lady works hard. Last year they went on a trip to Cleethorpes and the wildlife park."

The provider had a complaints procedure which was available to people who lived at and visited the home. Records showed that three concerns had been received in 2016. There was a record of both written and verbal concerns, along with any action taken. This included letters sent to the complainant with the outcome of the manager's investigation.

The people we spoke with told us they felt any concerns highlighted would be taken seriously by the management team and they would take action to address them. For instance, one relative said they had raised some issues about their relative's care with the new manager, and they had listened and been very responsive.

Good

Is the service well-led?

Our findings

At the time of our inspection the service did not have a manager in post who was registered with the Care Quality Commission. However, an acting manager had been appointed and at the time of the inspection and they were in the process of registering.

The people we spoke with said they were happy with the care provided and how the home was run. Relatives spoke about the positive changes that had been made since the new manager had been appointed. The comments we received from people's relatives included, "He [the manager] is excellent. He has an open door policy so you can talk to him. He has turned the home around."; "It's the best it's been. We have relative meetings now." and "He [the manager] is fantastic. He has done what he said he would do and things have really improved."

The provider gained people's opinions in a number of ways. For instance, people who used the service, their relatives and the staff we spoke will all said the manager always took time to speak with them and listened to what they had to say. There was also a suggestion box available in the reception area for people to post their opinions or queries. In addition, we saw the record of a relatives' meeting attended by the manager to gather people's views and explain the management team's priorities. We also saw that another meeting had been arranged for the near future to continue to gather people's views and to provide an update on the progress made so far.

We saw the results of the surveys that 10 relatives and 20 members' staff team had recently returned. Where any concerns or suggestions for improvement had been identified there was evidence the manager had discussed these in detail with each individual relative and staff member, taken their feedback on board, and taken action to address and improve in the areas identified.

All of this information had been collated and contributed to the manager's action plan, which meant that people's views were contributing to the organisation's view of the service, and any actions that were undertaken took people's feedback into account.

When we asked people if there were any areas they felt the service could improve people mostly commented positively about the overall improvements they felt had been made to the service provided. However, two relatives felt extra staff would be beneficial, especially on the ground floor, and one person talked about having more outings to places of interest.

Staff were also complimentary about the new manager. One staff member told us the manager was, "Always around encouraging you to do things." A care worker commented, "He's [the manager] made a difference from day one. He explains things, telling us what to do and the reason why we need to do it that way." When we asked staff if they felt there was anything the service could do better one person said some bedrooms needed redecorating, but added that work had commenced to decorate some bedrooms. Another staff member told us, "It's always improving."

There were audit systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the manager and the regional manager. The reports included any actions required, and these had been checked regularly to determine progress.

The manager told us they completed daily, weekly and monthly audits which included the environment, infection control, fire safety, medication and care plans. We sampled a variety of audits and it was clear any actions identified had been addressed in a timely way.

The manager told us company policies and procedures had been reviewed and updated to make sure they reflected current practice.