Healthmade Limited

Royal Court Care Home

Inspection report

22 Royal Court
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 10 and 14 September 2015 and was unannounced which meant the provider did not know we would be attending.

We last inspected this service in January 2015 where we found that the service was not meeting the requirements and was in breach of the regulations for: care and welfare of people, assessing and monitoring the quality of the service, management of medicines, consent to care and treatment, records and supporting staff. We took enforcement action for three of these breaches and informed the provider that they must take action to meet the regulations by June 2015. The provider also submitted action plans which set out how they intended to meet the regulations.

Royal Court Care Home is registered to provide care, accommodation and personal care for up to 40 older people in Hoyland, Barnsley. There were 31 people living there at the time of our inspection.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 not all of the actions in the provider's action plan had been implemented and little improvement had been made to remedy the breaches identified at our last inspection.

The provider was still not meeting the requirements of the regulation to ensure medicines were managed in a safe way. We saw that medicines were not always being stored and administered safely. Medicines were not managed and handled in accordance with recognised guidelines and the service's own policy.

Staff shortages at the service were not always covered and we observed that staff were rushed at times. Recruitment procedures were not sufficiently robust. Staff were still not provided with regular supervisions and appropriate training to ensure they were suitable and supported in their roles.

The provider did not ensure that people consented to their care and treatment in line with relevant legislation such as Mental Capacity Act 2005. It could not be demonstrated that decisions were always made in people's best interests. The registered manager had made, and was in the process of making, Deprivation of Liberty Safeguard applications to prevent people being subject to unlawful restrictions.

Risk assessments were not always in place for people where required, and we found systems for safeguarding people from abuse were not effective. Care records were reviewed at regular intervals however some updates did not reflect people's current needs.

Care records weren't holistic as little information was captured about people outside of their care needs, such as their backgrounds and social past times. People told us they would prefer more activities which contradicted with staff comments that people weren't interested in doing anything. Care was not being provided in a person centred way.

Comments about meals were mixed and we saw little choice being given to people. Although we saw staff assisted some people to eat, some people were not supported with appropriate prompting and encouragement.

We saw that people had access to external health professionals and this was evidenced in people's care records.

People spoke positively about the staff and how staff cared for them. However, observations showed an inconsistent approach from staff . Some approaches were kind and caring yet some were the opposite and staff spoke to people in commands. We saw instances where people's privacy and dignity was not respected.

No audits had been undertaken in order to monitor the quality or effectiveness of the service. Incidents at the service had been reviewed by the registered manager but not at a level that would identify trends and patterns. Staff told us they felt supported by the registered manager however team meetings were infrequent.

Observations showed that some aspects of the home were in need of attention, repair and cleaning. The provider told us they had no plan of redecoration and refurbishment for the home.

Residents and relatives meetings did not take place but the registered manager was trying to arrange these. No complaints had been made about the home at the time of our inspection.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key

Summary of findings

question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

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. People were at risk of unsafe treatment because medicines were not managed in a safe way. Individual risk assessments were not always in place where required.

The service did not ensure that sufficient numbers of staff were deployed at all times. People's dependency needs were not taken into account.

Systems and processes in place to safeguard people from potential and actual abuse were not effective. The recruitment process was not sufficiently robust to ensure staff were suitable to work at the service.

Is the service effective?

Inadequate

The service was not effective. Consent was not always obtained appropriately and in accordance with the Mental Capacity Act 2005 where people lacked capacity.

Staff did still not receive regular supervisions although each had received a recent appraisal. The training provided did not ensure staff had sufficient skills and knowledge for their roles.

The service did not actively promote and encourage people to maintain good nutrition. People had access to external healthcare professionals to help maintain good health.

Is the service caring?

Requires improvement

The service was not caring. People were pleased with the care they received and about the staff who supported them.

However, observations showed an inconsistent approach by staff towards people and some exchanges between staff and people were negative.

People did not always have their privacy and dignity respected.

Is the service responsive?

Inadequate

The service was not responsive. Care plans were reviewed regularly however people were not always cared for and supported in accordance with their needs. Staff did not always promote people's preferences and choices whilst providing support

There was a lack of stimulation available for people at the service and most people we spoke with told us they would like activities to participate in.

Relatives and residents meetings did not take place but the service was aiming to implement these. There was a process in place for dealing with complaints however some people's concerns had not been identified.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. The provider had not acted upon most action points they had put in place following our last inspection. No audits were undertaken to monitor the quality or effectiveness of the service and make improvements.

Incidents that occurred were not monitored in a way that would identify trends and patterns to prevent recurrences. Team meetings did not take place regularly.

The provider had sent out quality assurance surveys to people, staff and stakeholders who used, or were involved with, the service. No actions had yet been put in place from the results of these.

Royal Court 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.

The inspection took place on 9 and 14 September 2015 and was unannounced which meant no one at the service knew that we would be attending. The inspection team consisted of one adult social care inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to our inspection visit we reviewed the information we held about the home. We also contacted commissioners of the service, the local authority safeguarding team, and a community professional team involved with the home to ask for any relevant information they could provide about Royal Court Care Home.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included informal observations throughout our inspection. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with eight people, and one relative of a person, who lived at the home. We spoke with the registered manager, five members of care staff, the maintenance person and the cook. We reviewed the care records of five people and a range of other documents, including medication records, staff recruitment files and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People at the service told us they felt safe and said they felt comfortable with staff. One person told us, “I’m fully aware of malpractice and I wouldn’t tolerate anything like that.” Others said, “Yes I’m safe. I'm well looked after” and “They’re [staff] never violent and I don’t hear them shouting.” A relative said their family member was safe at the home.

At our last inspection we identified a number of concerns in relation to how medicines were managed and we took enforcement action against the home. We received an action plan which set out what the measures to be taken to address this. At this inspection we found continued concerns with the management of medicines. We checked the medicines and medication administration records (MAR) for five people. Of these records, none had photographs of the person within them and two people did not have their allergies recorded. Having a photograph and allergies recorded can reduce the risk of medicines being given to the wrong person or to someone with an allergy. We also saw that some MAR charts and topical cream charts contained gaps which meant it was unclear whether the medicines had actually been administered or not on these occasions. There was no guidance in place for medicines to be taken ‘as required’ to help assist staff as to when these should be administered. Clear protocols for such medicines are necessary to ensure medicines are given safely and when needed.

The service’s ‘Control of medicines policy’ said ‘medicines must not be left with the client for later’ and that the staff member should only sign the MAR once they ensured the person had taken the medicine. It states that the staff member administering 'will ensure medicines are taken as soon as they are offered'. At 10.30am we saw one person was seated with another person at a table in the dining room. The person had been left their morning medicines to take in a small plastic container with seven tablets placed in front of them on the table. No staff were present at this time. We shortly saw a staff member come over and pick up the tablets. They said the person sometimes refused to take their medication and took the tablets away. By leaving a person alone with their tablets, the staff member administrating would not have been able to ensure they had taken their medicines correctly.

We saw that some people had medicines significantly later than scheduled. For example one person required one of their medicines to be given at a specific time. We observed this person from 1.45pm to 3.20m and did not see them receive their medicine they were due to have at 2.00pm. We looked at their MAR chart which documented they had received their medicine at 2.00pm. The registered manager later told us that as MAR charts were pre-printed it was not possible to stick exactly to the times on these. However, there was a lack of robust system to record where people's medicines were administered notably outside of these times. This meant there was a risk of unsafe administration as it was not possible to ensure safe time periods between doses where this needed to be considered for certain medicines.

One person told us that they had been in pain for a long time and that pain relief medication they were taking did not give any relief to the pain. The person asked to speak to us about this and a care worker told us the person was always “moaning” about pain. The staff member told the person that the doctor said the pain was psychological to which the person became upset and disputed this. We saw in the person’s records that there was no reference to them seeing the doctor in relation to their pain for over a year despite their complaints. This showed that the person’s needs had not been managed to ensure they received the care they needed. We asked the registered manager to request this was reviewed by a doctor and during our second inspection visit we saw the medication had been adjusted. However, although details of the increased dosage were written in the person’s GP records, this was not written on the person’s MAR and an entry for the previous evening did not record the medicine had been given. When we asked a staff member about this they were unsure from the information available about what medicine the person should receive.

The medicines room where people's medicines were kept was unlocked on several occasions throughout our visits with no staff present or nearby. One morning, we entered the unlocked room and found a medicine trolley was also unlocked with access to people’s medicines. This demonstrated that medicines were not being stored securely and safely at all times.

The service had still completed no audits of their own with regard to medicines despite their action plan stating ‘auditing of all medication will take place on a monthly

Is the service safe?

basis and all audits recorded'. This meant there was still no suitable system in place for staff to check that medicines were managed, stored and administered in a safe way. The lack of monitoring did not safeguard people from risks associated with medicines.

Our findings evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were able to describe different types of abuse and steps they would take in order to protect people from abuse. The service had a safeguarding policy in place and information was present in the home about how, and where, referrals should be made. In one person's daily care records we saw an entry from August 2015 which referred to them being found in the early hours with 'three small bruises on their ribcage'. The person at the time had presented with discomfort and was unable to say how they had got the bruises. There was no corresponding incident form and the registered manager was not aware of this when we brought it to her attention. There was no evidence of any follow up in the person's records to establish how the bruises may have occurred. We asked the registered manager to discuss this with the local authority safeguarding team who requested a referral to be made. This showed that the systems in place had not been effective in ensuring people were suitably protected from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that potential risks to people were not always identified and assessed. We saw two people's care records which showed that they had bed side rails in place. There were no risk assessments in place for the people regarding the use of these. This meant possible risks may have been missed and therefore not effectively managed in order to maximise the safety of the person. We asked the registered manager to ensure these were completed.

People were not suitably prevented from the risk of infection as measures to prevent and control the spread of infection were insufficient. No infection control audits were undertaken and training was not provided to staff in infection control. We only saw one hand gel on display at the home which was in the entrance area. The registered manager told us, after the inspection, that staff practice was to carry individual hand gels on them.

The lack of effective infection control procedures had also been identified by health professionals working on behalf of the local clinical commissioning group who had visited the home in May 2015.

Our findings showed that care and treatment was not always provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were mixed views from people we spoke with about whether there were enough staff. Two people told us that staff sometimes, "Took a bit of time" to arrive when they used their call bell. One said staff were, "Too busy with domestic tasks." However another person said, "They answer it [call bell] quick and check on us every hour through the night.

At breakfast most people ate in the dining room. Staff told us breakfast started at 9.00am although we saw food did not start to be served until 9.25am. Seven people were already seated in the dining room at 8.20am and we noted that one of these people did not receive their breakfast until 9.50am. One person told us, "We used to have breakfast early at 8.30am but now you're lucky if you see it by 9.30am as carers are so busy." After tea time, staff were particularly busy supporting people. We found the rota identified four staff were needed but there were only three working at the time which had put extra pressure on staff. Throughout our inspection there was a lack of visible staff presence throughout the home at times.

Care workers told us that although they tried to meet people's needs they were often rushed at times. They said that many people at the home needed the assistance of two staff and they felt this wasn't taken into account. The registered manager did not use any dependency assessment to determine staffing levels to ensure these were suited to the needs of the people at the service.

We asked staff how staff absences and sickness were covered. Although staff told us they worked well as a team to cover shortfalls, there were occasions when staffing levels fell below what was meant to be in place in accordance with the home's own requirements. The service did not have any contingency arrangements to ensure absences could be suitably covered. One relative told us cleaners did not work every day. The registered manager confirmed this. Two weeks prior to our inspection, rotas

Inadequate

Is the service safe?

showed no cleaners had been scheduled to work at the weekend. The registered manager told us that this was in part due to absences and the home was looking to recruit further staff.

Our findings showed that sufficient amounts of staff were not deployed in a way to meet the needs of the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files of two recent members of care staff. For one employee, although their previous employer was listed as a referee, no reference had been obtained. There were two references in place for the second employee but it was not clear who the second reference was from. We asked the registered manager who was not able to clarify this further.

Each had a DBS (Disclosure and Barring Service) check in place. The Disclosure and Barring Service helps employers make safer recruitment decisions. The registered manager and provider told us these had been obtained prior to the staff member being able to commence employment. However, one person's DBS was dated almost two months after their start date. The provider and registered manager said the person would not have worked alone or unsupervised prior to having their DBS. However the lack of robust reference information and appropriate risk assessment meant the system did not adequately ensure staff were assessed as suitable to work at the service. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions.

Since our last inspection the registered manager had applied for two DoLS authorisations for people at the home which had been agreed by the local authority. She told us three more applications were currently in progress but no decision had been made at the time of our inspection.

We found that consent was not always appropriately obtained to show that people had agreed to decisions about their care. We found that the MCA 2005 had not been followed where people lacked capacity to make specific decisions. We saw one person's care plan which stated they lacked capacity to identify difficulties and risks. They had a care plan for mobility which stated they were at risk of falls. In the review of this care plan dated June 2015, the entry stated that 'side rails will be put in place' due to the person having recent falls. Bedside rails can present as a safety risk and can also be considered a restriction when used in certain circumstances. There was no record to show that the use of bed side rails had been discussed with the person and/or any family member or advocate they may have. We spoke with the staff member who had recorded this decision to ask how it had been arrived at. They told us they had discussed the use of side rails with the person but were not clear whether the person had capacity to consent. They acknowledged that nothing was documented in relation to this discussion. The service had an MCA 2005 policy and a consent policy in place. The consent policy stated 'It is essential for staff to document clearly both a person's agreement to the intervention and discussion leading to it.' Both policies gave guidance about how consent was to be obtained which had not been followed. As such, it could not be established the person had agreed to the use of the side rails, or that these were in the person's best interests and the least restrictive option. We saw that another person bed side rails also but there was no evidence at the time of our inspection to show they had consented to the use of these.

Our findings evidenced a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service's statement of purpose said that the service had a 'Comprehensive training programme which includes all mandatory training for existing staff' and 'All staff will receive training appropriate to their job role with any training needs being identified through observation, supervisions and staff.' We looked at a copy of the service's latest staff training matrix which the registered manager confirmed was up to date. We saw that a number of staff had recently undertaken training in safe handling of medication which we saw evidence of. She told us that staff were due to complete MCA and DoLS training in the next two months and some staff were shortly due to undertake end of life training. The matrix listed staff having completed moving and handling training, fire training and health and safety. Two members of care staff employed several months previously were not listed as having completed any training at the home which was also confirmed by the registered manager. We saw a number of gaps and lack of training in important areas. The two cooks and a member of night staff were not listed as having undertaken safeguarding training. Only two staff were shown to have undertaken training in infection control and this was in 2010 and 2013 respectively. The registered manager confirmed specific training was not provided in this area. No staff were shown to have training in key areas such as dementia and nutrition. Staff had not received suitable training to ensure they were appropriately equipped to meet the needs of people using the service.

Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. At our last two inspections we identified that staff did not receive regular supervisions or annual appraisals. The latest action plan from the provider said that staff would receive annual appraisals and regular supervisions which were 'ongoing and maintained.' We saw that each staff member had received an appraisal in June 2015 and we looked at sample of these. All except one member of staff told us they did not have regular supervisions, although all said they felt supported by the registered manager. Staff were not able to tell us the frequency of supervisions and some staff said they had never had one. At our inspection in January

Inadequate

Is the service effective?

2015 we looked at a staff supervision matrix which had documented 13 out of 30 staff having received one supervision since June 2014. At this inspection the registered manager provided us the same matrix again which now documented 14 out of 30 staff having received one supervision since June 2014. The only additional information recorded, was a supervision that had been completed in June 2015 for a senior staff member. The service's own supervision policy said that all staff would have a 3 monthly 'one to one supervision' which would be fully recorded however we found this was not the case.

Our findings showed that the service was still failing to ensure that staff received appropriate training, support, supervision and appraisals to enable them to carry out their role effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments from people about the food were mixed. These included, "Breakfast is ok, but just Weetabix and not enough," "The food is pretty good," "We have a set menu, but if I don't like it the chef will find something else if he has anything," "It's not always hot when it comes, or on time," " I can have it in my room or in the dining room, but it's not always hot," "The food is mostly good," "I'm a fussy eater but my needs are accommodated" and "Meals are not too bad at all. Nothing luxurious, usually basic meat taties and veg." We spoke with the cook and saw on the menu board that there was one choice of main hot meal for dinner although the cook said he would try to meet people's preferences of an alternative if they did not like what was on offer. On the first day of our inspection we saw at breakfast time that people were offered a choice of cereal or toast. We saw the cook fetch two people plates of beans on toast. We did not see anyone have a cooked breakfast. The cook told us cooked breakfasts were offered every other day. The registered manager and cook told us that people could still have hot choices every day although this did not extend to a full cooked breakfast.

We observed lunchtime service at the home. The majority of people ate in the dining room. The room was quiet and everyone was served the same meal. We did not see anyone being offered a choice and there were no condiments on tables. We saw staff provide support to some people who required assistance to eat their meals, however we saw that some people needed prompting and encouragement which was not provided. We saw one person in a wheelchair was taken into the dining room for lunch. The person was asleep during the meal service and we saw the person taken back into the lounge at 12.30 without having had any lunch. Improvements were required to ensure that people received appropriate support and provision with their nutritional needs.

People had access to healthcare professionals to help maintain good health. One person showed us a room and said, "That is where the Doctor comes when we need them, they come twice a week I think." The district nursing team involved with the home provided feedback and told us, 'The staff at Royal Court follow professional guidance very well and when asked to do things they do so.' Care records we looked at showed involvement of other healthcare professionals such as district nurses and specialist services such as the memory team.

We observed that many areas of the home needed attention. Some carpets, furniture and fabrics were heavily worn and stained as we found at our last inspection. We saw many areas throughout the home in need of cleaning and repair. The provider told us they did not have a plan of re-decoration and refurbishment for the home. One relative we spoke with told us, "It's not the care that's a problem. It is the building, it needs a good clean and decorating, the bathroom in [my family member's] room and other bathrooms are appalling, in seven years nothing has been updated [my family member's] bathroom is disgraceful and outdated." We saw one bathroom which had been under reconstruction to a wet room. Staff told us it had been this way several years. The provider, when asked, said it had been like this for 'a while'. They told us they hoped to have this completed by the end of 2015. Another shower room was malodorous and unclean. We also saw some areas in the home where plaster was coming off the walls. The home was dim in some areas, particularly on corridors which made it difficult to see clearly. We found that there was no signage and no points of interest to orientate people to where they were in the home which could be confusing for people living with dementia. One person commented that all the passages looked the same which made it difficult to find where they were and scared them.

We found that the premises were not suitably clean and properly maintained which was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

Most people spoke positively about the staff and the care they received. Comments included, “All the carers are very generous and I appreciate every one of them, they will do anything”, “Yes staff are very good”, “I like it here”, "The staff are wonderful, very caring, if they can do it for you they will", “My (relatives) come, they are happy with my care”, "Staff are alright" and “All the staff work hard and are pretty good, they do work hard.” One person told us, “It’s not home but they [staff] do try, do a good job”. Another said, “Some staff are good, some are indifferent. Depends what mood they’re in.” A relative told us their family member was happy at the home and that “The care is excellent.”

We saw that people’s rooms were personalised with their own items and keepsakes. Several people commented to us that they had “A lovely room” and had their own items in so they felt more at home. One person told us, “I have my photos and my own stuff around.”

Our observations of staff interactions with people showed an inconsistent approach of both positive and negative exchanges. We saw that some staff were kind, caring and patient with people. Some showed familiarity with people for example commenting on when they had last had their hair done and when their family was visiting. We saw one care worker find and tell a person that their relatives had arrived safely on a holiday they were taking which helped to reassure the person. However some exchanges were not caring and some staff spoke to people in a way that was brusque and sounded commanding. For example we heard a staff member telling saying loudly to a person who had asked for something, “You can’t have one if we haven’t got one.” Another person was told, “Stop doing that” when they tried to reach someone else’s plate when they were sat in the dining room. When someone asked for assistance when staff were supporting another person, they were told, “You’ll have to wait.” We noted that staff contact with people was mainly task based and there was little interaction seen outside of providing support. This meant there were limited opportunities seen for staff to build and develop relationships with people.

At one point we spoke with a staff member about a person’s medicines and medical conditions. The staff member told us the person was “a hypochondriac” which demonstrated an approach of the person being labelled by the staff member.

One person we spoke with was upset and told us they had earlier asked to speak to a care worker about the cause of their upset. They told us, “One of the carers told me to sit down and said we’d talk but she never came back. I know they’re busy.” With the person’s agreement we asked the registered manager if they could talk to the person about their concerns which they agreed to do.

We looked at four people’s care records. We found there was a lack of information about people, such as their background, families, likes and dislikes. The registered manager showed us three ‘life story’ documents that a volunteer at the home had completed with people which did capture this type of information. However, this was not present in people’s records. This meant there was limited information about people that would help and encourage positive relationships to develop for new staff or new people using the service. This had been an area that the provider had said they would improve at our last inspection.

We saw some situations where people did not have their privacy and dignity respected. In the lounge in the morning we saw someone in a chair with a blanket covering them. We saw that the blanket was soiled with visible brown stains and we asked a care worker to exchange the blanket which they did. In a communal shower room we saw a document on the wall that listed which people used continence wear and what size pads they required which we asked the registered manager to remove. The service was particularly busy after tea time and we saw staff assisting people who wanted to use the toilet. Several people were still sat in the dining room and one person asked several times for assistance to use the toilet. Although staff were nearby they were busy and did not acknowledge the person. We found a staff member and told them discreetly that the person wanted support to access the toilet. The staff member said, “I know, they all do” and we saw three people ‘lined up’ in wheelchairs outside the toilet whilst staff assisted people. This did not afford people dignity and respect. We also saw occasions where staff moved people in their wheelchairs without asking them, offering any explanation or having any communication about what they were doing or where they were going.

Requires improvement

Is the service caring?

Our findings demonstrated that people were not always treated with dignity and respect which was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

On the first day of our inspection the home felt cold in the morning. In the lounge we saw several people sat with blankets round them and people told us they were cold. One person said, "It's been cold for about a month. They [staff] tell me I have to have a blanket because they are not allowed to put heating on, I don't like blankets. Everyone's cold, I've been here two years but it's never been cold like this." Another person pulled their blanket around them and said, "It's cold" and another commented, "It's bit cool in here." Throughout the rest of our inspection people told us they often felt cold and some said the heating was not regularly on. Comments included, "Recently it's been very cold throughout the home", "It's warm in here today but was perishing yesterday", "It's been very cold the last few weeks" and "Some rooms are terribly cold." Some staff told us that people had spoken before about being cold in the home. The registered manager told us they were not aware of any complaints about people being cold and there were no problems with the heating. We noted that the corridors also felt cold and the registered manager offered to check the thermostats which had to be unscrewed to be adjusted. We found the three that were checked had not been turned not on. The registered manager and the provider told us they had not been on due to being turned off during summer. Due to the coldness in the home and what people told us, there had been a failure to identify this and to provide a service in a way that responded to the needs of the people who lived there.

At our last inspection we found the provider was in breach of the regulation relating to care and welfare of people. We found that care plans and risk assessments were not regularly reviewed, up to date and reflective of people's needs. At this inspection, most care records we looked at showed evidence of recent and regular reviews. Information present was person centred and detailed, however it did not always capture people's holistic needs. Pre admission assessments for people did not contain information about people's social preferences, activities and interests so these could be accommodated at the service. This information was not included within people's care plans which meant there was a risk they may not receive care in a way to suit their needs and preferences.

One person told us that they were encouraged to rise early in the morning but recently they'd been able to stay in bed a bit longer. They said, "I wanted to lie on my bed but they [staff] said I had to get dressed first. I'd have to be really ill if I wanted to stay in bed." We saw a note in the treatment room addressed to night staff about another person which read 'Please leave [name] in her wheelchair when you have got her up'. We asked why this was and staff told us the person's relative did not like to see them in distress by having to transfer the person into a 'comfy chair' which required the use of a hoist and then back to the wheelchair for breakfast. There was no information in the person's care plan to reflect this or to show that this was preferable for the person themselves.

The home's statement of purpose included the statement, 'The home offers a wide range of activities designed to encourage the clients to keep active.' The service did not employ a dedicated activities worker. Staff told that us that a member of kitchen staff had undertaken activities in the past with people but this did not happen now. Most staff told us, "People aren't interested in doing activities", "They're not bothered" and "They're happy to just sit in the lounge and watch TV". We saw a singer attend the home to perform in the lounge in the afternoon of our first visit. We heard two people comment that this was a "treat" and not something that usually happened. Apart from this there was little stimulation available for people. We asked people about activities at the home and the majority of comments were negative. People told us, "We used to do activities. Dominoes and cards. I don't know why we don't anymore", "We would like some activity. It doesn't happen as often as it should", "We just sit here with the TV on, we get very bored, anything would be better" and "We just need more activity, more to do to keep our minds active." One person said, "It's ok living here, but there's nowt to do" and another commented that, "There are no activities or trips out. It makes for long miserable days when nothing's happening." Someone told us about certain activities they had enjoyed in their past. They had not participated in these at the service and we asked them if they had asked staff to help them continue to enjoy these. They responded, "No, it won't get done." We found that people had limited opportunities to participate and engage in meaningful activity.

Our findings demonstrated that care was not always provided in a way to meet people's needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

The service did not currently have any residents or relatives meetings as a means for people to provide feedback or influence how the service ran. We saw that there was a notice in the reception area advertising that the service was looking to establish a residents and relative committee and people could sign up for this although it did not state what the purpose of this committee would be. The registered manager told us some people had asked about this and she explained to people what these were intended to do. She told us she had a good relationship with relatives and an open door policy.

We saw a complaints policy on display in the entrance of the home. People we spoke with told us they would tell staff or the registered manager about any complaints they had. People said, "She [registered manager] listens sometimes", "She always listens" and "She is very obliging." However, the registered manager had been unaware of the complaints people made to us regarding the heating. A relative told us about several on-going issues they had at the home and said the registered manager was limited as to what they could do to address these. They told us, "[Registered manager] Is very good but her hands are tied. She has the responsibility but not the power". Improvements were required in order to identify and act upon complaints in a way to resolve issues. There were no formal complaints being dealt with at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the service. Most people we spoke with knew who the registered manager was and spoke positively about her. Staff also spoke positively about the registered manager and another senior staff member who acted in a 'deputy manager' type role. One member of care staff said about this deputy staff member, "I'm not really sure what her role is, she does a bit of everything." We found that this person had responsibility for most of the operational activities at the home. When we asked the registered manager for information about people at the home during the inspection, they had to obtain much of this from the 'deputy'.

Staff said they did not often see the providers of the service at the home. A relative told us, "I have been coming here years, been to all the events over the years and the owner has never acknowledged or spoken to me once." The main view from people and staff was that the providers made the decisions about the home which meant the registered manager was restricted in what she was able to do and implement.

At our last inspection we found there was a lack of quality assurance and effective governance at the service and we took enforcement action. We received an action plan which set out how the service intended to remedy this. At this inspection we found few of the actions in the action plan had been implemented and little improvement made to address the issues.

The service had issued quality assurance surveys in June 2015 to people living at the home, relatives, staff and stakeholders. We looked at a sample of the responses to these from all sections. Most people's responses were happy with the home and the care however some comments suggested improvements. These included; more activities and new and more call bells for people. Another suggestion was the home needed 'a deep clean'. Following our last inspection, the registered manager stated that an action plan in response to the surveys would be completed by 30 September 2015. No progress or analysis of the feedback from these surveys was in progress at the time of our inspection.

The service had a policy in place titled 'annual development plan for quality assurance' which provided details about how the quality of the service would be monitored. This had been amended since our last inspection as it no longer stated the frequency of audits but it did state audits would be carried out in the areas of; catering, housekeeping, caring and administration. The provider's action plan said these audits would be undertaken quarterly. We found that none of these audits had been carried out and the registered manager confirmed they had not been completed.

Another action listed on the provider's action plan was that 'audits and checks of medication will be carried out on a monthly basis'. We found, and the registered manager confirmed, that no medication audits had been completed. The registered manager and the provider told us they were due to do one soon and said a copy would be provided at our request. We subsequently received this, however it was not an audit but a one page document that was not designed or completed in a way that would effectively identify and address any issues. This was supported by the fact that no issues had been identified yet this contradicted the many medicines concerns we had identified during our visits.

The quality assurance policy also stated that the manager and director would do a monthly 'walk around' of the service, speak to people, visitors and staff and document any areas of concern and take action where required. We spoke with the provider about their monitoring of the home to establish if this took place. They told us they liaised daily with the registered manager and said they were often at the home but did not document anything or compile any action plans. There was no evidence of any walk rounds and the registered manager told us this did not occur. The information about the providers being at the home often differed to what other people and staff told us. This showed that the service's own policies were not adhered to and there was no system in place to monitor the quality and effectiveness of the service at a provider level.

Another action on the action plan referred to care plan reviews being completed and said that 'care plan audits have commenced and are being maintained'. Although we saw that care plans were being reviewed, they were not being audited. One staff member was responsible for completion and reviews of all people's care plans, which they admitted was, "hard work.". This meant that when the staff member was on leave information did not always get updated. For example, one person's care plan said they

Inadequate

Is the service well-led?

needed a catheter but we later found this was not the case. This had caused confusion as the registered manager initially told us the person did have a catheter until staff told her otherwise. The registered manager told us this had only recently changed but the person's care plan in relation to their continence needs had not been updated as the staff member had been on holiday The reliance on one staff member meant that records did not always accurately reflect people's needs and were not always updated when these changed. At our last inspection there had been discussion about senior staff each taking responsibility for care plans but this had not taken place. The registered manager had very little involvement in care plans.

We asked staff how often they had meetings. Comments included, "Never had one", "Can't remember the last one" and "Few and far between". The registered manager told us informal discussions took place on a regular basis and staff were kept updated about information they needed to know by way of these. She told us there had been two formal meetings for senior staff in May 2015 and June 2015 and we saw minutes of these meetings. These minutes confirmed that senior staff had attended and there was an action included for a further meeting to be arranged to feedback information to the remainder of care staff. The provider's action plan also stated that full staff meetings would be held quarterly yet these had not taken place. Although staff told us they felt supported by the registered manager, the lack of formal meetings meant there was limited opportunity for all staff to be kept informed about relevant information, share good practice, discuss areas for improvement and any concerns.

We had also found that the actions in the provider's action plan to address the lack of supervisions had not been implemented as was required to ensure the service was compliant with the associated regulations. This showed another shortfall where actions to improve had not been acted upon.

A further action listed was that incidents and accidents would be reviewed quarterly to determine any trends such as 'particular areas of the building' and 'time of day'. We looked at a document completed by the registered manager which was a summary of accidents covering a seven month period from January to August 2015. The information was basic and was not detailed enough to effectively identify any patterns to try to reduce risks. For example, the document stated, '20 of the reports did not result in an injury' which were then discounted for further analysis for this reason. It stated '37 of the accidents/ incidents' were unwitnessed' with no further information such as where or when these had happened in line with the provider's action plan of how the information would be used. The lack of sufficiently detailed monitoring meant there was a continued risk that people were not being appropriately protected whilst living at the service.

The provider and registered manager told us that since our last inspection they had been working with support from the local authority and other external agencies in order to improve the service. Despite this, we found little improvement had been made and identified the same or similar shortfalls we had discovered at our last inspection.

Our findings demonstrated the service was not assessed and monitored effectively and in a way to identify and make improvements. Risks to people using the service were not suitably assessed in order to mitigate these and to promote people's health and welfare. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.