Roseberry Care Centres GB Limited

Molescroft Court

Inspection report

30 Molescroft Road
Beverley
North Humberside
HU17 7ED

Tel: 01482860367

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2016 and was unannounced. We previously visited the service on 16 April 2015. Since that time the registered provider has changed the company name and their registration with the Care Quality Commission. This is the first inspection under the new registration.

The home is registered to provide accommodation and care (including nursing care) for up to 44 older people, some of whom may be living with dementia. On the day of the inspection there were 33 people living at the home. The home is situated in Beverley, a market town in the East Riding of Yorkshire. There are three units within the home; The House, The Annexe and The Haven. Each unit has lounge areas, dining areas, bedrooms and toilets, and The House has communal bathrooms and shower rooms. People living in The Annexe and The Haven have en-suite facilities. Accommodation in The Annexe and The Haven is on the ground floor and there is a passenger lift in The House so people are able to access the first floor if they cannot manage the stairs. There are laundry facilities in The House and The Haven.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager has submitted an application to register with the CQC and we are aware that it is being processed.

On the day of the inspection we saw that there were insufficient numbers of staff employed to meet people's individual needs. New staff had been employed and more were in the process of being recruited, but in the meantime the home was reliant on a high usage of agency staff. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication was stored securely but some people had not received the correct medication and records were not completed accurately. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communal areas of the home and bedrooms were maintained in a clean and hygienic condition. However, we saw that it was not possible to keep laundry rooms in a clean and hygienic condition due to porous wall coverings and mops and buckets being stored in laundry rooms. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff, relatives and care professionals told us that the home was not well managed. Quality audits undertaken by the registered provider and manager were designed to identify any areas of improvement to staff practice that would promote people's safety. However, we noted that some of the shortfalls identified by us had not been identified in the audits that were taking place, or had been identified but not acted on.

This was a breach of Regulation 17 (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

The manager was following the home's recruitment and selection policies in an attempt to make sure that only people considered suitable to work with vulnerable people were working at Molescroft Court. However, we recommended that more care be taken with these processes as we noted one person had only one employment reference in place.

We found that improvements in staff training were needed as we were concerned that some staff had started work before they had completed thorough induction training and we saw there were some gaps on the home's training record. The manager told us how they were addressing these shortfalls. We made a recommendation about this in the report.

People told us that they felt safe whilst they were living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

People told us that staff were caring and that their privacy and dignity was respected. Most people told us they received the support they required from staff, although we received comments about people not receiving sufficient showers and baths. We made a recommendation about this in the report.

People's nutritional needs had been assessed and people told us they were very happy with the food provided. We observed that people's individual food and drink requirements were met.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and an outcome. There were also systems in place to seek feedback from people who lived at the home, relatives and staff.

Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about the CQC's regulatory response to any concerns found during this inspection will be added to the report after any representations and appeals have been concluded.

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 always safe.

People were not always receiving the correct medication and we identified errors in the recording of medication.

Most staff had been recruited in a safe way but there were insufficient numbers of staff employed to ensure people received the level of support they required.

Staff had completed training on safeguarding adults from abuse and people told us they felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they were undertaking induction training but there was a lack of evidence about the content. Some staff had not completed essential training although steps were being taken to bring training up to date.

The manager and staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were being met and people told us they were happy with the meals provided at the home.

Is the service caring?

Requires Improvement

The service was caring.

We saw positive interactions between people who lived at the home and staff.

Most people told us that their privacy and dignity was promoted and that they were encouraged to maintain their level of independence.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs had been assessed and care plans had been developed to record how these needs should be met. It had been identified that care planning needed to improve and this work was on-going.

Activities were provided and efforts were made to ensure that people were aware of the activities on offer.

People were informed about the home's complaints procedure and told us who they would speak to if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a manager in place who had applied to the Commission for registration.

Audits were being carried out to ensure that systems were being followed by staff and that people were receiving good care. However, we identified some concerns that had not been highlighted in the home's audits.

Some concerns were expressed about management and leadership at the home.

Molescroft Court

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 registered 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 10 and 11 May 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses / used this type of service. The Expert by Experience who assisted with this inspection had experience of accessing health and social care services.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority that commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) prior to this inspection and they returned it to the Commission within the required timescales. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home, three relatives, four members of staff, the manager and a registered manager from another service in the organisation. We also received feedback from health and social care professionals both before and following the site visit days.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for four new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Inadequate

Is the service safe?

Our findings

We asked staff how they kept people safe and they told us that their training on topics such as moving and handling, infection control and health and safety helped them to provide safe care. One member of staff said, "We report any hazards or potential risks." People who lived at the home told us they felt safe. One person said, "It's fine – I feel safe here" and another told us, "Yes, they are always there if I want them, they don't interfere." One relative told us that they felt their family member was safe at the home. However, two relatives expressed concerns. One relative told us that they felt the staffing levels and inexperienced staff meant their relative was not safe. They said, "I don't feel my relative is safe. Lack of staff, lack of experienced staff." Another relative told us, "There is a problem with one of the residents wandering around. When there are three staff it is fine, but where there are people needing to be assisted with feeding there is a problem."

When we arrived at the home at 9.15 am we saw there was only one member of staff in The House to support 10 people. We were told that there had been a second member of staff on duty from an agency but they had gone home; they later returned to the home but were absent for about one hour. There was no senior care worker on duty in The House so the senior care worker from The Annexe needed to administer medication in The House. When they went over to The House that left a new care worker alone in The Annexe to support 11 people. When we mentioned this to the senior care worker they asked the activity coordinator (who had just arrived at work) to remain in The Annexe to support the care worker. This meant there were insufficient numbers of staff on duty in the early part of the morning.

The standard day time rota was for two staff in The House and The Annexe and one member of care staff in The Haven. A social care professional told us that a family member had expressed concern that they had only ever seen one member of staff in The Haven to support 12 people, some of whom were cared for in bed. The manager told us that, when the new staff were in post, staffing levels would be increased to one senior care worker and two care workers in The Haven and The House and one senior care worker and a care worker in The Annexe. The current staffing levels during the night were one care worker in each unit and a senior care worker to cover all three units. The manager told us that this was due to be increased to five staff in total.

Ancillary staff were employed in addition to care staff. This included cooks, kitchen assistants, a housekeeper, domestic assistants, laundry assistants and a handy person. This meant that care staff were able to concentrate on supporting the people who lived at the home.

Relatives told us that more staff would be beneficial. One relative told us about occasions when they had arrived at the home and found that there was no staff or one member of staff in the unit. They had seen that staff were outside smoking and people who lived at the home had been left watching TV without supervision. This was also mentioned by a social care professional. One relative said, "The staff are good but there are not enough of them." Two relatives mentioned they had observed that the permanent staff were having to show agency staff how to carry out their duties so were extra busy. They said they were "Rushing around to deal with all the work." They were aware that new staff were commencing work at the home the following week and added, "Let's see what happens with new staff who are starting next week." One

member of staff described staffing levels as "Horrendous." Another member of staff said, "We use too many agency staff. Regular staff give those extra bits of care and residents are missing out."

A relative told us that their family member had not had a bath or shower for weeks, and that staff did not seem to have the time to support their family member with this, as the shower was in The House. A social care professional told us that, at a recent review, a person who lived at the home mentioned that they had not had a bath for a couple of weeks. This person had capacity and said they did not want to bother staff by asking. Another social care professional told us that a male had lived at the home since November 2015 and had only had five baths since that time. The family had spoken with the manager who had assured them that a male care worker would assist their father to have a bath but this had not materialised. We concluded that these shortfalls were related to there being insufficient numbers of staff on duty rather than any neglect by staff.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us that the home was always clean and that the laundry service was good. We walked around both units and saw that communal areas of the home and bedrooms were being maintained in a clean and hygienic condition. Domestic assistants were employed and we observed them carrying out their duties on both days of the inspection. There was a laundry assistant on duty each day. We noted that there was personal protective equipment (PPE) available for staff in various areas of all three units. However, we identified concerns in respect of laundry rooms in The House and The Haven. The laundry room in The House had been extended to provide a 'dirty' and 'clean' zone. The floor was washable but the walls were bare plaster so could not be washed effectively to keep them clean and hygienic. There were water heaters on one wall that we considered would be difficult to keep clean and dust free, and the window frame was in a poor state of repair and again, difficult to keep clean.

The laundry room in The Haven was smaller but attempts had been made to provide a 'dirty' and 'clean' zone. However, several mops and buckets were stored between the 'dirty' and 'clean' zones, plastic boxes to store clean clothing were stored above the bags holding dirty laundry and clean clothes were left to air above the sink. The meant that it was not possible to maintain the room in a clean and hygienic condition and there was a risk of cross contamination.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each unit had a medication cupboard or room. Medication was stored in a locked trolley that was fixed to the wall when not in use. In The House and The Annexe there was a medication fridge where any medication that needed to be kept cold was stored; the temperature of the fridge was taken and recorded each day to ensure medication was stored at the correct temperature. We were told that medication for people living in The Haven that required storage at a low temperature would be stored in the fridge in The House. The room temperature was taken and recorded in The Annexe but not in The House or The Haven. The care worker in The Haven told us that they had not been shown how to check and record the room temperature. This showed that there was a lack of consistency in the way medicines were stored. Although each trolley contained stickers to use to record the date when packaging on creams and eye drops was opened to make sure that these medications were not used for longer than recommended, none were being used.

Controlled drugs (CDs) for all three units were stored in the medication room in The House. CDs are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We

checked the amount of stock held in the CD cabinet and established that it matched the records in the CD book, and we saw that the records and stock held were checked twice daily by the senior staff members on duty so that any discrepancies were identified promptly. Audits of the medications systems in all three units were undertaken each month and submitted to the organisation's head office in the Key Performance Indicator report. We saw that issues had been identified in the audit for January 2016 but we did not see the audits for February, March or April 2016.

We spoke with three members of staff who were responsible for the administration of medication in each unit and they were able to describe the medication training they had completed. Some staff did not feel that they had received sufficient support to become competent in the administration of medication. On the day of the inspection we were told that eight staff had completed this training yet the training record showed that only three staff had completed this training. We concluded that the training record required updating.

We checked the medication administration record (MAR) chart folders. There was a laminated sheet for each person that included the person's name, date of birth, a photograph, any known allergies, details about how the person would like to take their medication and the level of assistance required. These were personalised apart from in The Annexe, where the information on the laminated sheets was more generalised. We checked the MAR charts for each unit and found concerns with both administration and recording.

In The House we identified that people's eye drops had not been administered as prescribed. One person was prescribed Alendronic acid, a medicine that needs to be administered once a week. The weekly dates were clearly recorded on the MAR chart but there were signatures indicating that the medication had been given six days in a row. We asked the manager to check this medicine and they assured us that the amount of medicine left in stock showed that it could not have been given on six days. We asked the manager to check with the person's GP to mitigate any risks. We saw that this person had not received the correct dose of Warfarin. Warfarin is an anticoagulant used to prevent heart attacks, strokes and blood clots. Regular blood tests are carried out and the dose is amended according to the results of the blood test. The errors that we saw indicated to us that staff had worked through the MAR charts on certain days and signed all available spaces without checking whether the medication was required or whether it had been administered. This is not safe practice.

We also saw that some people had not received their medication as prescribed in The Annexe and The Haven.

We saw that most handwritten entries on MAR charts had been signed by two members of staff. However, some had only one signature and the records for a new service user had no staff signatures. Records being checked and signed by two staff is recommended to reduce the risk of errors occurring when information is transcribed from labels on to the MAR chart.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Records evidenced that unused medication was disposed of appropriately.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When concerns had been identified in respect of a person's care, risk assessments had been undertaken to record how the risk could be managed and reduced. We saw risk assessments for moving and handling, the risk of falls, weight loss, pressure area care, the use of pressure care equipment, the risk of choking, use of a

catheter and infection control. People's pain levels were assessed using the Abbey pain scale, although we noted that there was no advice for staff on how to recognise that a person was in pain when they were not able to express this verbally.

On the day of the inspection a person who lived at the home told us about an agency worker who said they were going to "Lift them out of bed." They went on to say, "I told them it wasn't happening but they didn't seem to listen." Since the inspection we have received information about poor moving and handling techniques being used by staff and we have asked the registered provider to investigate and send us the outcome of their investigations.

We reviewed the folder where safeguarding information was stored. It included the local safeguarding board procedures and information about the threshold tool introduced by the local authority. The safeguarding 'threshold' tool had been used to identify whether the issue needed to be managed 'in house' or whether an alert needed to be submitted to the local authority safeguarding adult's team. The folder was divided into months and copies of any alerts submitted to the local authority were held along with any notifications submitted to the Care Quality Commission about incidents or allegations of abuse, deaths or serious injuries. Applications that had been submitted to the local authority to deprive people of their liberty were stored in the same folder.

Staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff also told us that restraint was never used at the home. We saw that information in care plans advised staff how to manage people's behaviours to reduce the risk of incidents occurring.

We checked the folder where accidents and incidents were recorded. The folder included information advice for staff on which accidents needed to be notified under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The folder contained a copy of all accident forms with a description of the accident or incident. We saw that one person had an un-witnessed fall resulting in a bump to their head. Appropriate medical advice had been sought and they were admitted to hospital so their condition could be investigated. The accidents for each month were listed and forwarded to the organisations head office for investigation; the most recent analysis had been carried out in January 2016.

We checked the recruitment records for three new members of staff. These records evidenced that an application form had been completed, references had been obtained (apart from a reference for one person) and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Molescroft Court.

Staff were issued with a staff handbook and a job description when they were new in post. This ensured staff were aware of what was expected of them. However, none of the personnel files included information about orientation to the home or induction training.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for portable electrical appliances, the passenger lift, mobility hoists, the fire alarm system and the call bell system. The gas safety certificate and electrical installation certificates could not be found on the day of the inspection. We received a telephone call

following the inspection to inform us that these were in place and copies would be forwarded to us. Slings had been serviced on 6 October 2015 and records indicated that the next service was due in April 2016; we did not see any records to evidence that this work had been carried out.

The handy person carried out in-house checks on the water temperatures, fire safety (including the fire panel, fire extinguishers, fire doors and emergency lighting), the call bell system and window opening restrictors. Visual checks of wheelchairs, shower chairs and bedroom safety were being carried out. Fire drills were also taking place; this helped to make sure people who lived and worked at the home understood what action to take in the event of a fire.

We saw that there was a business continuity plan in place that included details of everyone who lived at the home and staff, emergency contact numbers and guidance for staff on how to deal with a variety of emergency situations. There was a record of where the emergency evacuation bag / box was kept and that the content was regularly checked. In addition to this, there was a personal emergency evacuation plan (PEEP) for each person who lived at the home, although we noted that some we looked at did not record the assistance people would need to evacuate the premises in an emergency.

Requires Improvement

Is the service effective?

Our findings

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 MCA 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 in their best interests and as least restrictive as possible. We saw evidence that best interest meetings had been held to make decisions on behalf of people who lacked capacity to consent, and relatives told us that they were appropriately involved in decision making about their family member's care, including best interest decisions. We noted that only four staff had completed training on the MCA. Training on the MCA would provide additional evidence that staff understood the principles that they were required to follow.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that care plans included a DoLS checklist that was used to determine whether people were being deprived of their liberty. There was a record of DoLS applications that had been submitted to the local authority; at the time of this inspection decisions about authorisation were still being processed.

We saw that staff obtained 'implied' consent when they were supporting people throughout the day; they continually checked that people were happy with the care or support being provided. People had care plans in place about their capacity to make decisions and consent, and in addition to this, people had signed consent forms when they were able to do so. We saw consent forms in respect of photographs and the administration of medication.

Staff described to us how they helped people who lived at the home to make day-to-day decisions, such as choosing meals and clothes. Staff said, "We give people options and show them things. Some people with dementia are still well in other ways and we try to ensure they are still the person they were" and "We show them meals and clothes - we are always patient with people." One person told us, "I am vocal. I ask for it and it happens" and another person said, "I choose what I want to wear each day."

We asked people if they thought staff had the right skills. One relative told us that they felt the permanent staff were skilled and another said, "Some of them do have the skills. I don't know if they have training." We saw the home's training record and noted it recorded the training that was considered to be essential by the home. Topics included fire safety, food hygiene, moving and handling, health and safety, safeguarding vulnerable adults from abuse, the safe use of bedrails, infection control and nutrition / hydration. We noted there were some gaps in essential training; 11of the 23 care staff had not completed training on health and safety, food hygiene or the safe use of bedrails, ten staff had not completed training on nutrition / hydration and four staff had not had training on moving and handling. Most staff had attended training on safeguarding adults from abuse. Other training available to staff included medication (for senior staff only), pressure ulcer prevention, dementia awareness, end of life care and the Mental Capacity Act 2005 (MCA).

We asked staff what training they had completed in the last year. They told us that they had attended numerous training courses during the last few months, including moving and handling, safeguarding adults from abuse and medication. The manager acknowledged that training had 'fallen behind schedule' and told us that they had arranged recent training in an attempt to bring this up to date.

The manager told us that any new staff employed who had not already completed a National Vocational Qualification (NVQ) at Level 2 would start to complete the Care Certificate. The Care Certificate was introduced by Skills for Care, a nationally recognised training resource.

The training record showed that most staff had completed induction training. Some new staff had been employed and the manager told us that they were waiting for DBS checks and employment references to be received. However, we were concerned that the names of these new staff members were already included on the staff rota for the following week. In addition to this, staff, relatives and care professionals told us that they were aware new staff were going to be starting work the following week. One member of staff told us that they were concerned about how things would turn out the following week, as the new staff had only had one days' induction. We were concerned that staff might be allowed to start work without completing robust induction training.

One person told us that an agency member of staff "Tried to help me stand up on the wrong side – I have had a stroke. It frightened me in case they let me fall." Other people who lived at the home told us that they had requested that agency staff who did not have English as their first language should not assist them again, as they could not communicate with them and this made them feel vulnerable.

A new member of staff told us that they were not able to assist with moving and handling people as they had not yet completed the training, meaning they had started to work at the home before they had completed this training. We were aware that two units had two care staff during the day and one unit had one member of staff throughout the day. If one member of staff was not able to assist with moving and handling, this meant that a member of staff from another unit would have to be contacted to assist with this task.

We recommend that the registered provider follows care sector guidance on the induction and on-going training that should be undertaken by staff, including agency staff.

There was a supervision matrix displayed on the wall of the manager's office. The manager supervised all heads of units and senior care workers supervised the care staff in their unit. The head cook supervised catering staff and the head housekeeper supervised domestic staff. Staff told us that supervision meetings were events when they were 'told off'. The manager acknowledged this and told us that they were trying to promote supervision meetings as a two way process where staff could discuss their concerns and make suggestions, and would feel that they were listened to.

Nutritional assessments and risk assessments had been carried out and we saw that advice had been sought from dieticians and speech and language therapists (SALT) when there were concerns in respect of eating and drinking. Staff told us that people's nutritional needs were recorded in their care plans and that the information was also held in the kitchen. Some people had food and fluid charts in place and were being weighed on a regular basis as part of nutritional screening. We saw a sample of these records and noted that staff had been making appropriate records. However, a social care professional told us that they had been made aware of a person who had lost weight and that this had not been 'picked up' by staff. Staff had to be told to contact the person's GP and when they did, they informed the GP that there were no concerns about the person's eating and drinking and did not tell the GP about the weight loss.

We observed the serving of lunch in The Annexe and The House. There was a four week menu on display but we noted it was written in small print so was not accessible to some people. On the day of the inspection there were two choices of main meal and dessert and the menu recorded additional choices. Drinks were provided. One person requested scampi and chips and it was made especially for them. People told us that they liked the meals. Comments included, "Food is fine. I'm a picky eater. I don't eat veg. so they don't give them to me. Sometimes give me cereal at night as that puts me to sleep" and "I am very fussy – if I don't like it they will give me something I like. They spoil me." We noted that tables in The House dining room were set with tablecloths and placemats, but only with placemats in The Annexe, and there were no condiments on the table. We noted that staff were needed to assist people who ate their meal in their room, which meant they did not stay in the dining rooms / areas. This happened on both days of the inspection and we felt this did not promote mealtimes as a social occasion as there were no staff to encourage conversation and interaction.

Staff told us they would recognise if someone was unwell, even if they could not verbally express this, because they got to know people very well. We saw that any contact with health care professionals was recorded, including the reason for the contact and the outcome. People's records evidenced that advice that had been sought from health care professionals, such as district nurses, chiropodists, occupational therapists and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. One care plan recorded a visit from a dietician and that the dietician had recommended the person was provided with homemade milkshakes. Care records evidenced that this advice had been followed and that the person had been provided with homemade milkshakes and smoothies. We saw there was a form in care plans that recorded any contact made with people's relatives and relatives told us that they were kept informed about events such as GP visits.

There was a record of any injuries or pressure areas on body maps to assist staff with monitoring the person's condition, and there was a record of any pressure area equipment that had been provided.

People had patient passports in place although we saw that some were not fully completed. Patient passports are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff.

One relative told us that their family member's bedroom door was painted a different colour and that this, along with signage, helped them to find their way from their bedroom to the bathroom and back. We saw that bedrooms in The Annexe had pictures on the door to help people recognise their room, such as a picture of flowers with the words 'I love flowers' and the picture of a factory with the words 'I used to work in a factory'. There were three or four of these statements on each door. We noted that bathrooms, toilets and other communal areas of the home had clear signs to help people orientate themselves around the home.

Some areas of the home were not easy to access. Rooms in The Annexe had steps up to them and one bedroom had a steep ramp to negotiate. The windows in The Annexe and The Haven were Perspex rather than glass; some of them had become opaque and difficult to keep clean, so were difficult to see through. Some areas were in need of re-decoration. The walls of the passenger lift needed to be re-covered; they were currently covered in glue after the previous covering had been removed.

Requires Improvement

Is the service caring?

Our findings

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient in the way they interacted with people. One person who lived at the home told us, "The staff are all very pleasant and caring, that's the regular staff. Sometimes they are pushed because there aren't enough staff." A social care professional told us that relatives were generally happy with the care and support provided for their family members. A relative told us that they felt staff genuinely cared about the people who lived at the home. They said, "Staff are 'touchy feely' and that seems to work. They have a sense of humour and so do the residents so there is a nice atmosphere." Other relatives said, "The majority of staff care. Some of the staff are absolutely lovely but some of them are looking for other jobs" and "Regular staff do. But when staff were changed they didn't know how to care for my relative properly – they didn't have time to read the care plan."

Staff told us they were confident that all staff genuinely cared about people who lived at the home. They said, "It would soon be picked up if people were not right for the job."

One relative told us that their family member was encouraged to remain as independent as possible. She said that staff encouraged them to dress themselves (with supervision) and that they also encouraged them to go downstairs for lunch. The relative felt that this was important so their family member had some exercise and some interaction with other people. However, they said that sometimes staff did not remember to do this, probably because they were so busy. On one occasion we saw that a member of staff assisted someone to take a drink rather than ensuring they had a beaker they could drink from without assistance.

We saw the notice that informed people about Dignity Champions within the service. This described the role of the champions, which was to promote good practice within the service. Care plans did not include information about people's preference in respect of being supported by a male or female care worker. One relative told us that they did not think people's modesty was being protected during personal care, partly because they were assisted by someone of the opposite gender. However, one person who lived at the home told us, "They make having a shower private for me" and a female who lived at the home told us, "We have a lot of male carers but it hasn't bothered me." A member of staff told us they would always ask females if they are happy to have a male assist them with personal care. Staff gave us examples of how they protected people's privacy and dignity by ensuring curtains were closed and covering them with a towel to protect their modesty.

A relative told us they were not satisfied with the personal care their family member received. They told us that their relative had continence issues and needed to wear an incontinence pad. Staff were not assisting this person with personal care to ensure that they were dry, comfortable and free from malodour. The relative told us, "[Name] has not had a shower for weeks as staff don't seem to have time. The shower is in The House - many of the staff don't have the skills to deal with my relative." This showed us that some people who lived at the home were not receiving personal care in a way that protected their dignity.

Three people who lived in The Annexe mentioned that they were not able to use their en-suite baths. They

said that they would prefer a shower, but if they wanted a shower they had to go to The House. The manager told us that they had requested that a shower or 'wet room' be provided in The Annexe and was hopeful that this would be agreed.

We recommend that the registered provider ensures staff adhere to best practice principles in respect of privacy and dignity.

We saw that there were information leaflets displayed in the home, such as those from the Alzheimer's society and community transport, but we did not see any information about advocacy. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Discussion with staff revealed there were people living at the home with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

A relative told us that their family member was visited at home by staff from Molescroft Court so that a care needs assessment could be carried out. Other relatives were aware that their family member had a care plan but said they had not asked to look at it. The new style of care plan included information about a person's level of involvement with their plan. One care plan recorded, 'I wish to be involved in my care plan. I wish my relative / advocate to be involved' although we noted this record had not been signed.

The care records we saw included care needs assessments, risk assessments and care plans. Assessments included an overall dependency assessment plus assessments for moving and handling, falls, pressure area care, the control of infection and nutrition. Assessments were scored to identify the person's level of need and any associated risks. Any risks were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk. Care plans covered areas such as eating and drinking, sleep, hearing and eyesight, mobilising, communication, skin care, maintaining a safe environment, personal care, memory, capacity and consent, medication and end of life care.

Care records included a document called 'This is Me' which contained the headings 'The person who knows me best', 'I would like you to know', 'My home and family and things that are important to me' and 'My life so far'. There was also information about the person's hobbies and interests; this gave staff useful information that they could use to get to know the person better and therefore provide more person-centred care. Care plans also included information about a person's preferences for care, such as, "[Name] prefers to eat meals in her room. To be repositioned to eat safely." Some staff told us they did not have time to read care records, especially agency staff, and they suggested that a care plan summary might be useful.

One person told us that their care plan was reviewed; they said that their relative and Social Services were involved and that "Everything is discussed." A social care professional told us that, at a recent review, they had noted that risk assessments and care plans were out of date, and that this was being addressed by the current manager. On the day of the inspection we saw that care plans were in the process of being updated. There were some discrepancies in care records. For example, one person had a risk assessment in place because they had a catheter yet their dependency assessment recorded, in respect of continence, 'has full control'. Another person had a 'Do Not Attempt Resuscitation' (DNAR) form in place but this was in the middle of their care plan and would have been difficult to locate. One person had a bed rail in place but the consent and best interest decision had not been completed and the bed rail position check form was not dated. This was fed back to a manager on the second day of the inspection and we were assured that these anomalies would be addressed when each care plan was re-written and updated.

We noted that the staff rota for the day of the inspection was not a true record of the actual staff on duty; the same staff were at work but they had been assigned to different units. Staff and relatives told us that staff were sometimes moved to another unit to work. The manager had told them this was to prevent them from becoming "Institutionalised." Relatives told us that they understood this, but that it had a detrimental effect on their family member as they no longer had familiar faces to relate to and were not always receiving person-centred care.

We recommend that care plans are an accurate record of each person's care needs and that these are used to enable staff to provide a consistent service.

Staff told us that they were expected to arrive 15 minutes early for their shift so they could handover information to the next shift. They said that some staff were not arriving 15 minutes early so handover meetings were sometimes hurried, so a thorough meeting could not take place. Staff felt that this might be because they were not paid for this 15 minute period.

Relatives told us that they were able to visit the home at any time and people who lived at the home told us that their relatives were made welcome. Comments included, "They are offered cups of tea" and "When my relatives visit they are offered lunch."

We saw the activities sheet that had been prepared for May 2016. This included photographs of previous activities plus planned activities for the month that included a pamper day, a musical morning, snakes and ladders, reminiscence, needlework, gentle exercise, film shows and manicures. Comments from people who lived at the home about activities included, "We had a church service from Toll Gavel Methodist Church", "We receive an activities sheet and I'm on the front page", "[Name] came to entertain; he was good", "Exercise lady was good" and "My picture is in the middle." One person told us that they had their hair done each Thursday by the hairdresser and that the chiropodist visited, and that the activities coordinator did their nails. Other people preferred to arrange their own activities. One person told us, "I do my own thing. I watch my TV, DVD's and do crossword books, and I love reading." They said they went out with their family and visited charity shops to buy more books. Following a suggestion from a relative, a visit to a local farm had been arranged and we saw that there were notices throughout the home advertising this. There was also a notice inviting people to a tea / coffee and cakes plus musical performance in The Haven on 17 May 2016.

Some people told us they had received a survey to complete and one person said, "I get involved if there is a big meeting." Records evidenced that surveys had been distributed to people who lived at the home and three surveys had been returned. Issues had been raised about car parking, poor communication with families and the lack of shower facilities. Specific surveys had been distributed about housekeeping / laundry, activities and food. Two housekeeping / laundry surveys and five food surveys had been returned. None had been analysed but the manager told us that the feedback would be analysed and the outcome shared with people who lived at the home and staff.

One relative told us that they were confident that any concerns or complaints they expressed would be dealt with in a satisfactory manner by the manager or staff. Another relative told us they had raised a complaint with the manager and it had been dealt with to their satisfaction. However, a third relative told us that they had complained to the manager, then to the organisation. They told us, "The organisation took the manager's view and supported the manager" so they did not feel their complaint had been dealt with properly. Another relative told us, "I can approach any member of staff but I'm never sure if they are permanent, bank or agency." People who lived at the home told us that they would leave it to their relatives to complain on their behalf. Staff told us they would try to resolve minor complaints themselves, but if the complaint was more serious, they would pass it to a senior care worker. They were confident that people would be listened to.

We saw that the complaints procedure was displayed in the home. We checked the complaints log and saw that any complaints received had been recorded, including details of any investigation and the outcome. Letters of satisfaction were also recorded.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was not registered with the Care Quality Commission (CQC) but they had submitted their application for registration and we were aware that it was being processed.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that most of these were well kept, easily accessible and stored securely, although on the first day of the inspection when the manager was not at the home, staff told us they were not able to access quality assurance information.

We asked staff about the management of the home. Two members of staff told us that the manager was not approachable but they felt the new deputy manager was more approachable and would listen to them. Another member of staff told us they often felt the manager was "Trying to catch me out." A new member of staff told us they "Loved working at the home." A relative told us that the home was well managed and that there was a "Nice atmosphere." However, another relative said, "It's been a bit awkward with the changeover. There have been three or four new managers since we have been here."

A social care professional told us that the manager was currently working to make improvements with the service and staff, and "Is willing to work with all parties involved to ensure that all residents' needs are understood and met." However, another social care professional told us that a family had expressed concerns about the management style of the manager. Most people who lived at the home were aware of who the manager was. Comments included, "I've seen the manager occasionally but then I don't see them" and "I think I've met the manager but they seem to pick and choose who they talks to."

A relative told us that communication from staff at the home had improved in the last couple of months. They said that they received emails to update them about any concerns, and that they also received a newsletter. Another relative told us that they were aware that relative meetings were being introduced. We saw information on the notice board advertising relative meetings in January, April, July, September and November 2016. We also saw the minutes of the meeting held in April 2016 were displayed on the home's notice boards. We noted that two relatives attended along with people who lived at the home. The topics discussed included the new activities coordinator, the home's newsletter and the new management structure.

The meetings folder was divided into months and we saw that meetings for people who lived at the home, relatives and staff were held on a regular basis. In January 2016 there had been a staff meeting when the topics discussed included taking 'split' breaks, afternoon refreshments, staff rotas, staff handover, infection

control and staff were informed that wheelchairs should never be used without footplates being fitted. Staff told us that they were invited to express their views at the end of staff meetings but that they were not sure they were listened to.

Surveys had been distributed to staff and seven had been returned. All staff commented that they believed people received good or excellent care and two members of staff commented that they had not completed induction training. The outcome of the survey had not been analysed but the manager told us the feedback would be analysed and shared with the full staff group. Three surveys had been returned by people who lived the home. Issues had been raised about car parking ('a nightmare'), poor communication with families and the lack of shower facilities. Some of these issues were raised with us during the inspection so it was apparent that people's feedback had not always been acted on.

Staff describing the culture of the home said "There is a lack of consultation and staff are not spoken to respectfully" and "and "Very negative. It is affecting the service users as well. We don't have enough time to spend with them and they know things are different." A social care professional told us that staff morale was reported to be low and that this was affecting people who lived at the home, as they had picked up this atmosphere.

We checked the quality assurance records and saw that a month-end quality key performance indicator (KPI) report was completed each month that recorded audits on medication, pressure ulcers, weight loss, bed rail safety, outbreaks of infection, infection control, hospital admissions and catering. These were sent to the organisation's headquarters for further analysis. However, we noted that the audits that were carried out had not highlighted the concerns we identified, or when they had been highlighted, they had not been acted on, such as medication errors and the prevention and control of infection.

This was a breach of Regulation 17 (2) (a) (b) (e) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staff told us that they talked to each other to make sure they learned from any incidents or mistakes to try to make sure they did not happen again.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had quality assurance systems in place but these had not effectively assessed, improved and monitored the quality and safety of the services provided, or mitigated the associated risks. Regulation 17 (2) (a) (b) (e)