Crown Care I LLP

The Royal Care Home

Inspection report

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Ratings

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

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

The Royal Care Home is situated in Rossington on the outskirts of Doncaster. The service provides both nursing and personal care for up to 57 older people and those living with dementia.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We saw there were systems in place to protect people from the risk of harm. We observed some staff responded well to people and understood their individual needs, however we saw some staff were not as caring and supportive.

Summary of findings

We found that people were supported by sufficient numbers of qualified, skilled and experienced staff. However, we saw there were occasions where people were left for periods of time without staff intervention. We saw a training matrix which reflected that some training had not been completed and individual staff supervision sessions were not taking taking place regularly.

Suitable arrangements were in place to support people to maintain a healthy intake of food and drink but views about the quality of food were mixed. Staff were aware of people's nutritional needs and ensured these were met effectively.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. Support plans contained a good level of information which explained how to meet the person's needs. People told us that they had been involved in developing their support plan and felt they contributed on an ongoing basis.

We observed staff supporting people with whom they had developed good relationships and could recognise their needs. Some staff were very respectful and ensured privacy and dignity was maintained. However, some staff had not developed relationships with people and we observed incidents where dignity was not maintained.

Everyone we spoke with said they felt comfortable raising concerns but some did not receive follow up or feedback after they had raised concerns.

The provider had a system to monitor and assess the quality of service provision. This included giving people the chance to have their say and an opportunity for the provider to improve.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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.

We found that safeguarding procedures were in place and staff knew how to recognise, respond and report abuse. They had an understanding of how to safeguard people they supported.

Staff were available to meet people's needs, however they were not always deployed in the areas they were needed.

Support plans contained risk assessments associated with people's care and support. However, most people had a safety gate fitted to their bedroom door. We were told this was to prevent people going in other people's bedrooms. We saw no risk assessments associated with safety gates. The provider had not carried out mental capacity assessments or risk assessments in relation to safety gates fitted on bedroom doors.

Recruitment processes were in place although they were not always followed. Evidence of some pre-employment checks were missing from staff files. This did not help reduce the risk of the provider employing a person who may be a risk to people using the service.

People were not always supported to make decisions.

Is the service effective?

Requires Improvement

The service was not always effective.

We looked at four staff files and saw that staff did not always receive one to one meetings (supervision). The staff we spoke with said they did not receive supervision sessions on a regular basis. We spoke with staff who told us they received appropriate training. Staff told us that the training they received was worthwhile and gave them confidence to carry out their role effectively. We saw records which confirmed some training had taken place. However, the records also identified some gaps in training.

People told us they felt comfortable discussing their health needs with the staff. Support plans showed where people had seen medical professionals such as the G.P, community nurse and dietician.

People who used the service were supported to have sufficient to eat and drink and to maintain a balanced diet. We saw that support plans were in place to identify assistance required in this area. The plans also identified what people liked and disliked and their individual choices.

Is the service caring?

Requires Improvement

The service was not always caring.

Summary of findings

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with and support people who have complex needs. There were instaces where people's dignity was not promoted or maintained.

People had signed to confirm they agreed with their care plan. Where people were unable to sign, we saw that relatives had signed on the persons behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed prior to them using the service and a care plan was devised which involved the person and their relatives. We saw that care delivered was not always in line with the person's individual care plan.

We saw two activity co-ordinators during our visit, but there was very little activity taking place for people who used the service.

The provider had a complaints procedure and responded, in a timely manner, to concerns raised. People we spoke with felt comfortable to talk to staff if they had a concern. However, some people felt they did not get any feedback after they had raised concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager showed us the audits which were completed on a monthly basis. We saw that audits covered all aspects of care and welfare as well as any environmental issues. However, we saw audits which had identified concerns, but there was no action plan with a timescale in place to address these.

Accidents and incidents were monitored and the service ensured that any trends were identified and action taken to address concerns.

The Royal Care Home

Detailed findings

Background to this inspection

We inspected the service on the 5 and 11 August 2014. The inspection team consisted of two adult social care inspectors, a specialist advisor in dementia care 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 care service.

We last inspected The Royal Care Home on the 26 June 2013 and found the service was not in breach of the regulations we checked at that time.

At the time of our inspection there were 50 people using the service. We spoke with seven people who used the service, ten relatives, six staff, two nurses and the registered manager. We also looked at documentation relating to four people who used the service, four staff and the management of the service.

We spent time observing care in the dining room, and lounge. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people using the service, who could not express their views to us.

Before our inspection we reviewed the information we held about the service.

We spoke with the local council contracts team who shared concerns relating to recent safeguarding alerts. We met with the provider, the local council contracts lead and the investigating safeguarding social workers in-between our inspection. This was to gain an insight into recent issues.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service and their relatives and we received mixed responses. Some relatives felt their family members were safe but others were concerned about the number of staff available and linked this with safety. We observed staff and found that on occasions people were left for periods of time without staff present. For example we saw that one lounge where 14 people were sitting, were left unsupervised for 25 minutes without any staff presence. During this time one person tried to take the foot wear off another person and people were coughing and required assistance. We also noted that during this time three care workers and an ancillary member of staff were standing talking together in the corridor nearby. We also observed several members of staff to walk by the lounge door, but they did not enter or interact with people. One relative said, "This is why we come, to make sure our relative is alright." We observed that whilst there were enough staff around, they were not deployed to the right areas. This left people who used the service at risk. We spoke with the registered manager about staffing levels and he told us that he had identified improvements in deployment of staff was required and was in the process of addressing this.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how staff were recruited. We saw there was recruitment and selection processes in place which detailed the pre-employment checks that were required to be obtained prior to staff commencing employment. These included two references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. We looked at four staff files and found that pre-employment checks had not always been carried out in line with the company policy and legal requirements. Obtaining all of the required information about a person helps employers make safer recruitment decisions.

Two staff files we looked at did not have evidence that a criminal records check had been carried out and there was no evidence that this had been followed up. We saw two files which had references missing and there were no evidence that this had been followed up by the registered manager. This put people who use the service at risk as the provider did not have all of the required information about each person to make sure they were suitable and safe to work in a care environment.

This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with 10 staff and two nurses and the manager about their understanding of safeguarding vulnerable adults. We found they had a good knowledge of safeguarding and could identify the types of abuse, signs of abuse and they told us they would inform the registered manager if they witnessed any incidents. Staff we spoke with told us that they had received training in safeguarding vulnerable adults. This was supported by a workbook which staff were expected to complete. However, some staff we spoke with were not aware that they could also contact the local council or the Care Quality Commission regarding safeguarding incidents if they felt their concerns were not being addressed.

We saw evidence that the registered manager had referred safeguarding incidents to the local authority safeguarding team and to CQC. We saw the registered manager kept a log of these incidents and evaluated them based on the outcome. All correspondence relating to safeguarding incidents were also filed with the log. This meant the registered manager had evidence of actions taken and the outcome of the investigations.

Care and support was planned and delivered in a way that ensured people's safety and welfare. We looked at care records belonging to four people and found they included risk assessments which identified any risk associated with their care and how support was provided to protect people. We looked at examples of risks that had been identified which included falls, malnutrition, mobility, tissue viability and supporting people who displayed behaviour which may challenge the service.

Staff had some awareness of the Mental Capacity Act, but only five staff had received training in this area. The Mental Capacity Act 2005 (MCA) 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 ensures where someone may be deprived of their liberty, the least restrictive option is taken. Staff knew that people should be involved in making their

Inadequate

Is the service safe?

own decisions. We saw that where people lacked capacity, and where decisions were made in the person's best interest, these took into account the person's likes and dislikes.

We saw safety gates were in place on the doorway of a large number of people's bedroom doors. We spoke with staff regarding their purpose and they told us they were in place to stop other people using the service going into bedrooms. There were no risk assessments or records in place for ensure the use safe use of the gates including consideration if these amounted to a deprivation of liberty.

We spoke with family members about this and one person said, "I would worry about my relative's safety if the gate was not on the door, as other residents go in my relative's room." The registered manager told us they had discussed the use of safety gates in relation to a potential deprivation of liberty with the local authority who is the supervisory body. They reported they were told an application would not be required due to the purpose being to keep people out of the rooms rather than preventing people from leaving their room. Staff told us that only people who were able to operate the gate could have one on their door however we observed that not everyone was able to operate the gate.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff who told us they received appropriate training. Staff told us that the training they received was worthwhile and gave them confidence to carry out their role effectively. We saw records which confirmed some training had taken place. However, the training records identified some gaps in training, for example, there were 38 care staff listed on the training matrix and some had not completed training considered as mandatory by the provider. We saw that five care workers had not completed safeguarding training, 17 had not completed health and safety and Control of Substances Hazardous to Health (COSHH) training, five care workers had not completed moving and handling training and 15 had not completed infection control training. We saw that only five care workers had completed training in Mental Capacity and Deprivation of Liberty Safeguards (DoLS). We spoke with the registered manager about this and were told that 31 staff had been signed up to complete Mental Capacity and DoLS training.

We looked at four staff files and saw very little evidence of supervision sessions, (one to one meetings with their line managers), being provided to staff. Regular planned staff supervisions are important as these provide a formal framework to reflect on practice and performance and can be used to identify any training needs or areas of development.The staff we spoke with said they did not receive supervision sessions on a regular basis. The staff records we saw did not contain evidence that routine checking of their competencies took place in areas such as medicines administration. We spoke with staff who told us they could shadow experienced staff as part of their induction, but the timescale for this was determined by the management. This was not reflected in the staff files as no evidence was available.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service were supported to have sufficient amounts to eat and drink and to maintain a balanced diet. We saw that support plans were in place to identify any assistance required in this area. The plans also identified what people liked and disliked and their individual choices. During the two days of our inspection we spent time observing lunch both upstairs and downstairs. We saw that people appeared to enjoy their food and staff assisted them where required.

We spoke with staff about what they would do if they identified any concerns associated with the person's diet. Staff were knowledgeable about when they should contact the GP or other professionals such as the dietitian and the speech and language therapist.

We saw drinks and snacks were offered to people. People we spoke with had mixed comments about the meals. One relative said, "Food is moderate. It varies quite a lot particularly the potatoes, sometimes they are black inside." Another relative said, "Food can be good and bad, its inconsistent. Custard is served without sugar." We asked staff about this and were told the reason was due to some people requiring a diabetic diet. This meant that some people's choices were not always considered.

People were supported to maintain good health and have access to healthcare services where required. We saw that care records contained information about referrals to other professionals and records were reflective of appointments and contacts with professionals. Records showed that referrals to other professionals such as a dietitian were completed without delay.

We spoke with people and they felt comfortable and able to discuss healthcare issues with staff. Relatives felt involved and told us they were informed of any concerns. One relative said, "When my relative was ill the staff contacted me straight away." Another person said, "When my relative had to go into hospital the home contacted us."

Requires Improvement

Is the service caring?

Our findings

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with people who had complex needs.

We spoke with relatives of people who used the service and received mixed comments. One relative said, “Care is exemplary by some members of staff, others not so.” Another relative said, “I would change half of them (the staff) they don’t really care, it’s just a job.” Another said, “The staff seem fantastic, their skills seem genuine.”

We saw some staff interacted with people well and had developed good relationships. For example, we observed lunch in one dining area and saw staff offering choice and respecting the person’s decision. We saw some care staff took every opportunity to talk with people, listened to what they had to say and showed a genuine interest. We saw these staff treated people with dignity and respect.

In contrast, we saw several instances where staff ignored people and did not listen to them. For example, we observed lunch in another dining area and saw staff talking over people and not including them in their conversation. We also oberseved a person being assisted in to the dining room by two care workers. The person was assisted to walk across the dining room and was assisted in finding a place to sit, but no conversation or explanation took place with the person during this time. We saw other staff who walked past people without acknowledging them. The only interactions for some people were when staff were carrying out a task such as assisting people to mobilise and then conversation was limited to instructions.

We saw one person who had eaten their meal in the lounge. When the person had finished their meal a care worker moved the plate away. The person had food on their clothes and face but nothing was done to assist the person with their hygiene needs.

We also observed a person being transferred from their wheelchair to a lounge chair. During this process the person’s trousers fell down to the floor and the care workers sat the person in the chair. They then stood the person up and pulled their trousers up. Care workers informed us that the person wore braces but they did not have time to put them on that morning. This lack of attention by staff did not preserve the person’s dignity.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw evidence in care plans where people and their relatives had been involved in their care. People had signed to say they agreed with their care plan. We asked people what they would do if they saw something in their care plan which they didn’t agree with and they told us that they would discuss this with the staff and manager.

We spoke with staff who gave examples of how they would preserve dignity. One person said, “When delivering personal care I close the curtains.” Another person said, “I use a towel to make sure the person is covered up.”

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them using the service and a care plan was developed which involved the person and their relatives. Likes and dislikes and individual preferences were recorded in people's care plans. Some staff had a good awareness of people's choices and they were able to respond to people in accordance with their individual needs and wishes. However, some staff did not seem to be aware of people's individual preferences. We saw one person being assisted with their lunch and the person was spitting the food out of their mouth. The care worker carried on trying to assist the person. We asked the care worker why the person may be spitting their food out and were told that the person must not like the food offered. No alternative food was offered as a choice, but a desert was given.

We saw some activities taking place during our inspection, but these were limited. We saw a short church service took place in one area and we saw an activity co-ordinator sitting with one person showing them a book. We were made aware of a recent boat trip and were told that another one was planned. We spoke with staff, people who used the service and their relatives and were told that although a recent boat trip had taken place very there were few activities planned. One person said, "There's not enough for my relative to do, there needs to be more." The staff we spoke with felt that there was no stimulation for people who used the service and no input from outside the home, for example books, magazines and newspapers.

Some people we spoke with had some positive comments about activities. One relative said, "We had a party for my relative in the lounge." Another relative said, "I wanted to take my relative out but I was unable to push the wheelchair, so a member of staff came with us."

We saw the garden area was accessible to people and their relatives. Everyone we spoke with said they enjoyed this space. One person said, "I like the garden, it's very beautiful." A relative said, "They (staff) have thought about the safety aspects in the garden and it's lovely to go outside safely." Another relative said, "My relative and I planted plants in the raised flower beds."

We spoke with the registered manager and were told that the home had three activity co-ordinators, one of which had been employed recently. Although there were two activity co-ordinators at the service during our visit, we saw very little activity taking place for people who used the service. We saw that care plans did not reflect people's recreational needs. This did not show that the provider had considered people's community involvement and independence.

Care records were held electronically on a care planning system. Each member of staff had their own access to the system. There was a computer upstairs and one downstairs but all staff on duty needed access so they could record events as they occurred. We saw that this had created some problems, for example, one care record dated 23 January 2014, showed that the weight of a person had been recorded three times in one day. The weights fluctuated from 61.9 kg to 63.2 kg. We spoke with staff who said that this could be because the person entering the information entered three weeks weights at the same time. This meant that the records were not accurate.

One person who had been assessed as being at high risk of malnutrition had a care plan which stated that food should be cut up into small pieces and snacks provided due to poor diet. We asked to see the food record charts for this person and were told that none were in place as the person eats well. This was contradictory to the care plan. This meant the persons individual needs were not being met in line with their care plan.

Another person's care plan stated that an assessment had been completed for the use of bed rails and had been deemed inappropriate. A crash mat had been provided and the care plan identified the need for this equipment. However, there was no detail in the plan on how to safely use the crash mat and when this should be in place.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a complaints procedure and people knew how to raise concerns. People we spoke with said they felt they would be listened to if they needed to complain. There was evidence that learning from complaints took place. Since September 2013 the service had received six complaints which were logged and showed that staff meetings were held to discuss the lessons learned and supervision sessions took place where required. All correspondence was saved in the complaints file.

Requires Improvement

Is the service responsive?

We saw that a residents and relatives meeting had taken place in July 2014, which was well attended. The registered manager told us that people had the opportunity to espress their views and opinions about the service.

The relatives we spoke with felt they could raise issues and felt the registered manager listened to them. We spoke with people who used the service and their relatives about raising concerns. One relative said, “I feel respected and listened to by the manager. They always ask how I want a concern dealing with.” Another relative said, “I feel staff are approachable and they seem to listen but I don’t get any follow up or feedback regarding my concern.” People who used the service told us they felt able to raise concerns with staff.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission.

People who used the service and their relatives, were asked their views about the care and support they received. A recent satisfaction survey had been sent out to people at the beginning of July 2014 and some responses had been received. The responses from this survey had raised issues about the lack of activities. The provider employed a third activity co-ordinator in response to this. However, on our inspection we saw two activity co-ordinators were available but very little activity taking place. The survey had also raised concerns about people being left in the lounge without a staff presence. During our visit we observed that people were left alone on one occasion for 25 minutes. During this time people required the support of staff. This meant staff were not deployed effectively and consequently people were not being cared for appropriately. Although the registered manager informed us this they had identified this through their quality monitoring systems and were in the process of addressing this, improvements had not yet been implemented in practice.

The registered manager showed us the quality audits, which were completed on a monthly basis. We saw that the audits covered all aspects of care and welfare as well as any environmental issues. However, we saw audits which had identified concerns, but there was no action plan with a timescale in place to address these to ensure and confirm the necessary improvements were made. For example the kitchen audit was completed in August 2014 and highlighted the need for a second food probe to test the temperature of cooked food. There was no date identified for the action to be completed. The kitchen audit for July and August 2014 indicated that a new fridge was required due to a door seal fault, again there was no date for action to be taken or expected date for completion. The registered manager told us that they had introduced a new corrective action plan which would be used in the future to identify areas for development. We saw that one of these had been completed in relation to a staffing issue. This showed that the registered manager had started to implement improvements to address this.

Visits to the home were carried out by the regional manager, usually every three months. Recent audits had been completed in February 2014 and August 2014. This audit looked at areas such as quality assurance, accidents and incidents, complaints and general maintainance. There was an action plan produced following the visits.

The registered manager told us and we saw that they completed night visits as part of the quality monitoring of the service. Two had been completed in 2014, one in January and a second in April. One of the visits had identified that there were insufficient food supplies available for supper. The manager told us that this had been addressed. We also saw a record of what action had been taken.

Accidents and incidents were monitored by the registered manager to ensure any trends were identified. We spoke with the registered manager who explained that the accident analysis was produced by the electronic care recording system. This produced a report which highlighted details about the accident. This was monitored on a monthly basis. We saw where one person experiencing a high level of falls had been refered to the falls clinic which showed action had been taken address this concern and keep the person safe.

The registered manager had initiated a staff council to support staff. This was operated without the registered manager being present and gave staff the opportunity to speak with their peers. Some staff we spoke with had found this very supportive. We spoke with staff and were told they did not receive supervision sessions on a regular basis. The staff records we looked at supported this.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person did not operate effective recruitment procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure that people's dignity and independence were maintained as far as practicable, or to enable service users to make, or participate in making, decisions about their care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that appropriate training, professional development, supervision and appraisal took place regularly.**