Healthmade Limited

Royal Court Care Home

Inspection report

22 Royal Court
Hoyland
Barnsley
South Yorkshire
S74 9RP

Tel: 01226741986

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 25 July 2016. The inspection was unannounced. This meant no-one at the service knew that we were planning to visit.

Royal Court Care Home is registered to provide accommodation and personal care for up to 40 older people in Hoyland, Barnsley. There were 28 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 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.

At the previous inspection on 9 and 14 September 2015 the service was rated inadequate and placed into special measures by CQC. This inspection found that there were not enough improvements to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Care staff understood what it meant to protect people from abuse. They told us they were confident any concerns they raised would be taken seriously by management. However, there were no systems in place to monitor any allegations of abuse and any action taken.

Not all medicines were stored safely. There were no systems in place to regularly audit whether medicines were being administered correctly.

We saw that safe recruitment procedures were not always followed to ensure that all the required information and documents were in place before staff commenced employment. These procedures were required to verify people employed by the service were suitable to work with vulnerable adults.

Not all staff were provided with regular supervisions and appropriate training to ensure they were suitable for their job and supported in their role.

There were not enough staff to meet the needs of people living at Royal Court. We saw staff were rushed. People told us they needed more staff and more things to do.

The registered manager did not always ensure people consented to their care and treatment in line with relevant legislation such as Mental Capacity Act 2005. It could not be evidenced decisions were always made in people's best interests.

The registered manager had applied to the Local Authority for Deprivation of Liberty Safeguards (DoLS) to be authorised for some people living at Royal Court.

Care records were not always regularly reviewed. There was no evidence people's views and aspirations were taken into account when care records were reviewed.

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

People living at Royal Court told us staff were caring. Staff we spoke with understood what it meant to treat people with dignity and respect and we saw they did this.

People living at Royal Court and staff working there, told us the registered manager was approachable and responsive to any concerns they had.

There was no evidence of regular quality audits being undertaken to ensure safe practice and identify any improvements required.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports 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 safe.

Medicines were not stored safely and there were no systems in place to ensure that medicines were administered correctly.

Systems and processes in place to safeguard people from potential and actual abuse were not effective.

There were not enough staff to meet the needs of everyone living at Royal Court.

Risk assessments were not always completed or reviewed regularly. This meant that care and treatment was not always provided in a safe way

Safe staff recruitment procedures were not fully adhered to.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity, consent was not always obtained appropriately and in accordance with the Mental Capacity Act 2005.

Staff did not receive regular supervision in line with the service's own policy or enough appropriate training to support them to carry out their jobs effectively.

People told us they liked the food served at Royal Court and there was plenty of choice.

People had access to external healthcare professionals to help maintain good health.

Is the service caring?

Good

The service was caring.

People living at Royal Court and their relatives told us that staff were caring.

We saw staff interact positively with people living at Royal Court.

Staff knew what it meant to treat people with dignity and respect and we saw people had their privacy and dignity respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were very limited activities available to people within Royal Court and no opportunities to leave the premises to visit local amenities. People told us they would like more to do.

Care records were not always reviewed regularly and the information recorded did not always accurately reflect the person's current level of need.

There was a complaints policy in place, but no record of concerns that were raised informally and any actions taken to resolve them.

Is the service well-led?

Inadequate

The service not well-led

There was no evidence of regular quality audits being undertaken. Where audits had taken place by the service there was no record of any findings or any actions to be taken as a result.

People living at Royal Court and staff working there were not regularly asked for their views of the service.

The service continued to be in breach of regulations 9, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that were identified at the previous inspection in September 2015.

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.

This inspection took place on 25 July 2016 and was unannounced. The inspection team was made up of two adult social care inspectors.

Prior to the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury.

Before our inspection we contacted staff at Healthwatch and they had no concerns recorded. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted members of Barnsley council contracts and commissioning service. They told us they were continuing to monitor the service and trying to support the registered provider to improve as they had concerns regarding the level of risk to people living at Royal Court.

During the inspection we spoke with 10 people who lived at the service and two of their relatives. We spoke with two visiting health professionals. We met with the registered manager and two registered providers. We spoke with five members of staff. We spent time looking at written records, which included four people's care records, five staff files and other records relating to the management of the service. We spent time observing the daily life in the service including the care and support being delivered by staff. We checked the medication administration records for people living at Royal Court.

Inadequate

Is the service safe?

Our findings

Our findings
We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

When we arrived at Royal Court we saw the medicines trolley was left unattended while the member of staff went to answer a call at the door. We saw that there were two pots of medicines left on top of the trolley, eight packs of eye drops and an opened packet containing a patch used to help with pain relief. We spoke to the member of staff about this and we were told they had asked a colleague to 'keep an eye' on the trolley. We didn't see any evidence of this. By leaving the trolley during the medicine round with some medicines already dispensed into pots there was a risk of confusing who the medicines were for on returning to the trolley. In addition the medicines could have been picked up and consumed by anyone passing by.

We observed part of the medicines round at lunchtime. Some people's medicines were put directly on the tablecloth, instead of in a medicine pot. We saw this member of staff cough into their hands and then continue with the medicines round. Not sanitising hands and placing medicines directly onto tablecloths meant there was an increased risk of cross infection.

We checked medicines were stored safely and at the correct temperatures to ensure optimal effectiveness. The treatment room temperature had been recorded daily and was not always below 25 degrees Celsius, which was the service's own policy. There was no record of any action taken to rectify this. The temperature of the fridge used for storing medicines was consistently above the NHS guidance of between 2 and 8 degrees Celsius.

We were told a medication audit is undertaken every six months by Boots chemist, who provide the prescribed medicines and by the most senior member of care staff every three months. The registered manager confirmed the only medicines audits undertaken in 2016 were completed internally in January 2016 and in June 2016 by Boots. The Boots audit had identified that the fridge used for storing medicines was not maintaining optimal temperatures. This had not been addressed by the time of this inspection on 25 July 2016. This meant the service continued to not have systems in place to regularly audit the safe storage and administration of medicines. Where a problem had been identified action had not been taken to address the issue.

We looked at Medication Administration Record (MAR) charts for people living at Royal Court and found some improvements had been made in this area. The charts we looked at had photographs of the individual concerned to ensure correct identification of the person and there were no signature gaps in any of the records. The meant senior members of care staff had signed to say they had given a person their medicines and they had taken them or a reason was given and signed to say why the medicines had not be taken, for example the person was in hospital.

Some medicines were prescribed PRN, which meant they were given as and when required. We saw where PRN medicines were prescribed they were often signed for on the person's MAR chart as 'offered but not required.' There was no evidence of this being reviewed and a backlog of PRN medicines had built up.

This meant there continued to be no suitable system in place to check medicines were managed, stored and administered in a safe way. This continued to be a breach of Regulation 12, Safe care and treatment.

We found the care records we looked at showed some reviews of risk assessments had continued to take place since the previous inspection. However these records didn't always show reviews had taken place as often as they were supposed to. For example, one person was assessed as being at very high risk of pressure sores and the guidance was to review this situation weekly. The care record showed reviews were only taking place monthly. A further example was a person who had been assessed with regard to their risks of falls; the outcome was that this situation should be reviewed monthly. No review had been recorded since April 2016. This meant that care and treatment was not always provided in a safe way. This continued to be a further breach of Regulation 12, Safe care and treatment.

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found that 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, Safeguarding service users from abuse and improper treatment.

People we spoke with told us they felt safe living at Royal Court. Care staff we spoke with told us they had received training in safeguarding vulnerable adults from abuse. The training record confirmed that care staff had this training within the last two years and newer staff were booked onto this training in September 2016. Not all ancillary staff had received recent training in this area. All staff we spoke to were able to tell us what abuse was and the many forms it can take. They were all confident their concerns would be taken seriously by management.

The service had an up to date safeguarding policy and a whistleblowing policy. Whistleblowing is when a member of staff raises a concern about wrongdoing at their place of work. Staff we spoke with knew this and again were confident any concerns they had would be taken seriously by management. They were not aware who to contact if their concerns were regarding management and this was not stated in the policy. Staff told us they would look for contact details on the internet or report their concerns to CQC.

The registered manager told us there had not been any safeguarding incidents since the last inspection and therefore there were no safeguarding records of any actions taken and lessons learnt for us to view. However, CQC had received six alerts of allegations of abuse since the last inspection in September 2015. Three of these had been made as a result of concerns found during that inspection, of which two were regarding poor pain relief management and the other was regarding unexplained and unrecorded bruising. Of the remaining three concerns, one was regarding poor moving and handling techniques, one was about a medication error and the other regarding staff shortages. This continued to be a breach of Regulation 13, Safeguarding service users from abuse and improper treatment.

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found 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, Staffing.

One person told us, "We are short of staff. Sometimes there are only two on duty. Have to wait for [support

to use] the toilet most of the time." Another person told us, "There is a shocking lack of resource, staff don't have time, very short staffed all the time."

A relative told us, "There are never enough staff, sometimes I have to go looking for them, they are usually in the kitchen preparing tea or something." Another relative said, "[Royal Court] could do with one or two more staff."

Comments from staff we spoke with included, "There is only time to meet basic needs," "Feel rushed, feel like I am running all the time," "[Staff] don't always have time to sit with people," "Some [people] have deteriorated and need two carers. Some people do have to wait," and "There are not always four care staff on duty, [this happens] at least twice a week. We try and cover sickness ourselves, agency staff aren't used." We asked the registered manager about this and she confirmed that it wasn't always possible to have four care staff on duty during the day and three at night due to staff sickness and holiday leave.

Throughout the day of our inspection we saw staff were rushed and had little time to sit and spend quality time with people living at Royal Court. We saw people asking for support to use the toilet and being told they would have to wait. There were four members of care staff on duty plus a cook and kitchen assistant. There was also a laundry assistant and domestic assistant employed during the morning until 1.30pm.

We asked the registered manager how they calculated how many staff were required on each shift to meet the needs of the people who lived at Royal Court. We were told, and staff rotas showed there should be four care staff employed during the morning and afternoon shifts and three during the night shift. This was in addition to ancillary and domestic staff. People's care records contained risk assessments that identified their level of dependency in each area of daily living and this information was used by the registered manager to work out staffing levels. We were shown a care staffing levels calculator that recommended the amount of care staff hours required per person per day dependent on their level of care needs. The registered manager told us she worked this out by looking at every person's care record and we saw that she had identified seven people with high levels of dependency. According to the calculator the maximum support any person could receive was four hours per day. There were people who required two care staff to mobilise safely and to attend to their personal care needs. Some also needed support to eat and drink. These people required more than four hours of care per day to meet their basic health and social care needs. This continued to be a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found 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, Fit and proper persons employed.

Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires certain information and documents to be obtained to demonstrate a thorough recruitment process has been followed to ensure fit and proper persons are employed. This includes evidence of a disclosure and barring (DBS) check taking place and satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care or children or vulnerable adults and where a person has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable of the reason why that person's employment ended.

We found that three of the four staff recruitment files we looked at did not include a photograph of the

member of staff and the other file did not include a copy of the member of staff's proof of identity such as their birth certificate or driving licence. We asked to see recruitment files for staff who had been employed in the last 12 months. One of these files did not contain references from their previous employer. The references were from a family member who had previously worked with their relative and the other reference was from a friend. This meant that safe recruitment procedures were not being followed and this continued to be a breach of Regulation 19, Fit and proper persons employed.

Requires Improvement

Is the service effective?

Our findings

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was a Yale lock and a star key deadlock on the front door of Royal Court. People had to ring the doorbell to be let in and had to ask a member of staff to unlock the door with the star key to get out. This meant people's liberty at Royal Court was being restricted. The registered manager told us and we saw that she had applied to the Local Authority for DoLS authorisations for 11 people living at Royal Court. So far one had been refused and two had been granted. The registered manager was aware of her responsibilities with regard to DoLS.

Care staff we spoke with had an awareness of mental capacity and told us they had received training in this area. We saw it was recorded that care staff had received training in understanding mental capacity and DoLS in December 2015. Care staff were able to tell us how they supported people to make day to day decisions such as what to wear and what to eat. People's care records contained information when the person had capacity to consent to care and treatment. However, where a person did not have capacity this was not clear. None of the care records we looked at contained evidence of best interest decisions taking place. This would have included an explanation as to why the decision was necessary and why it was in the person's best interest.

We saw one person with capacity had signed their consent to using bed rails. However, we saw a person who lacked capacity also had bed rails in place. Bed rails can be used effectively to keep people safe and reduce the risk of falling, however they can also be used as a form of restraint to prevent people from getting out of bed. There was no record of a best interest decision regarding the use of bed rails on this person's care record. This continued to be a breach of Regulation 11, Need for consent.

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found the service was failing to ensure 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, Staffing.

The registered manager showed us the training matrix they had completed for all staff. The matrix was designed to show either a date in the future when the member of staff was due to undertake a specific training session, or a date in the past to show when they had completed it. In addition some training needed to be completed more than once in order to keep up to date with current legislation and any innovations in practice, for example safe moving and handling techniques. The training matrix and the 'staff training, development and supervision policy' did not indicate how often training should take place.

The matrix showed that no staff had undertaken dementia training since 2011 and there were no future dates planned. Half of the care staff had not had moving and handling training since January 2012. Three members of care staff were recorded as not ever having had any moving and handling training. Nearly all care staff had undertaken end of life training and health and safety training in the previous 12 months. All staff should undertake fire training. Two members of staff hadn't completed this training and nearly half hadn't completed any fire training since 2012.

The 'staff training, development and supervision policy' stated that 'all staff should have a three monthly one to one supervision with the manager and an annual appraisal. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next 12 months. We were given a copy of the staff supervision and appraisal record which showed supervision was not taking place every three months for any staff. Most staff had a supervision session in January, February or March 2016 but nothing since. Everyone had an appraisal date recorded for some time within the next five months.

Comments from staff regarding frequency of supervisions and appraisals were variable. One long standing member of staff told us they would talk to the registered manager if they had any problems, but they had never had any formal supervision type meetings with her. Two members of staff told us they had supervision every three months with the registered manager, and had regular appraisals.

When we looked at staff files a member of care staff had no supervisions recorded on their file and it was not clear when they had started with the service. The remaining three staff files showed that each of the members of staff had supervision in January or February 2016, but nothing recorded since. All three had an appraisal in 2015.

We looked at a file for a new member of care staff, there was no record of any induction, training or supervision on this person's file. The service's policy states that all new members of staff would have an induction and those new to the social care profession would be 'helped to achieve the Care Certificate.' There was no evidence of this. The person's start date with Royal Court was also unclear.

This continued to be a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found that the premises were not suitably clean and properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment. During this inspection we found some improvements had been made in this area.

The communal wet room was completed and the other shower room was closed for refurbishment. There

were also two bathrooms and four separate toilets for the use of people living at Royal Court. Bedrooms had ensuite toilets and sinks.

Some people residing at Royal Court were living with dementia. The inside of the home didn't have a particularly dementia friendly approach. There was little signage to orient people to their environment, such as coloured doors or memory signs/ boxes. There were bold, swirly patterned carpets in some of the lounges and in some of the corridors the carpet on the floor was stuck to the lower half of the corridor wall. Some of the corridors were poorly lit making it difficult to see where you were going. This meant the environment could be particularly challenging to someone living with dementia as floor space was not clearly defined. Some improvements were still required in this area.

People told us they liked the food at Royal Court. Comments included, "Food is OK, there is a really good cook," "Food is nice, can't grumble, we are never hungry and there is a good variety of meals," and "Food is very good, good chef, meets my needs. Good variety of food and always get enough."

We saw there was a four week menu cycle. The main meal was served at lunchtime with an alternative of soup and toast. Tea was usually sandwiches with an alternative of a simple hot meal such as cheese on toast. There was a cooked breakfast option available every day as well as cereals and toast. Some of the people living at Royal Court required a soft diet and we saw this need was catered for.

We saw that all staff at lunchtime were aware of peoples likes and dislikes. Although staff were rushed we did see them supporting people to eat in a dignified way. People were offered drinks both with their meal and a hot drink afterwards. Where people didn't want to eat much they were offered alternatives such as biscuits or toast and encouraged to eat these instead.

Care records showed that people had access to a wide range of health and social care professionals. For example, we saw that GPs and community nurses visited people regularly where required and some people had been referred to the memory clinic for support.

Good

Is the service caring?

Our findings

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect. During this inspection we found improvements had been made in this area.

Comments about the staff were generally positive. People living at Royal Court told us, "Staff look after me well, I am satisfied with that," and "It's alright here," "Most of the staff are committed, staff are trying harder but it is still all task and no time though."

Relatives we spoke to were also satisfied with the care their family member received. One relative told us, "[Royal Court] is the best I could hope for, nothing is perfect. I have done research of other places, here I have support from staff."

There was a 'comments book' in the reception area of Royal Court. It contained four comments, all positive from December 2015 onwards. One visitor wrote, "I have noted a great improvement in cleanliness. Staff as caring and friendly as ever."

We spoke with two visiting health professionals during this inspection and they were very complimentary about the staff. One health professional told us, 'Staff are caring, [staff] know patients and what is going on with them." They explained that a member of care staff usually stayed with the person when they were treating them and this, "Gives reassurance and helps promote dignity." We were also told that they have always found staff caring and helpful, "but now they are asking for advice and support. 100% confident they would let us know if any problems."

During our inspection we saw people's bedrooms were personalised, and contained their personal effects such as photos and pieces of furniture. Most people's bedroom doors were identifiable as they displayed the person's name and sometimes a picture or a photograph. Where this wasn't the case the registered manager told us this was the person's choice.

All staff we spoke with were aware of peoples likes and dislikes. They were able to give examples of people's food choices and what they liked to do. They told us how they would support one particular person if they became agitated, "I sing and dance with [name of person] as it helps to calm them down."

One member of care staff told us, "Residents become like family." All staff we spoke with understood what it meant to treat people with dignity and respect. They were able to give examples of ensuring privacy through closing doors when providing personal care and knocking on closed doors before entering a room. Staff talked about covering people up with a towel when providing care. .

We saw staff interact positively with people living at Royal Court. Several people needed support to eat and drink. We saw care staff assisting with this task, explaining to people what they were eating before

presenting it to them. In all but one situation care staff sat down next people while gently encouraging them to eat. In this single incident a member of staff stood up while supporting the person to eat. This meant communication with the person was difficult as the member of staff was bending over them.

It wasn't always the same member of care staff supporting the person with each course. We saw care staff rushing to serve everyone their meal while the food was hot so no one was left waiting. Overall this did not create a relaxing environment. This meant some of the people requiring support at meal times may have felt rushed and unsure which member of staff was supporting them.

Requires Improvement

Is the service responsive?

Our findings

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found care was not always provided in a way to meet people's needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

During our inspection there was no activities timetable on display to let people know what events, if any were happening that day. We spoke with the registered manager about this who told us there was a timetable, but this was in the treatment room. We were told and we saw the treatment room was always locked when not in use so people living at Royal Court did not have access to this information. We asked the registered manager what activities were available and we were told they tried to offer activities every day and these included bingo, ball games and skittles. We asked if there was any one to one time available for staff to spend quality time with people and we were told that, "Staff do try and sit with residents when they can." The registered manager told us they did not employ an activities coordinator.

Royal Court's 'statement of purpose' had been updated since the previous inspection in September 2015. The section on 'social activities, hobbies and leisure interests' contained the statement, 'There are many local opportunities for the residents to enjoy an active social life; cinemas and theatres, libraries and social clubs are within easy access.' We asked the registered manager about this who told us there were not any trips out planned as they were unable to provide enough staff to ensure people's needs were met away from home.

We asked people living at Royal Court what activities they enjoyed. One person told us, "I am bored, sat all day, nothing going on, it makes me feel tired. I watch TV if I am lucky. Staff put on TV, [we are] not given a choice. I used to like to go shopping but don't get to go out anywhere now. I am depressed. I don't like being cooped up in this place."

Other comments from people living at Royal Court included, "[There are] no activities apart from the occasional game of bingo. I don't get to go out, can only go in the garden," and "Feels like living in a morgue."

We saw there were skittles, hoopla and large font bingo cards in one of the lounges. We asked the people sat in the lounge about this and we were told, "We play when staff have time." People told us they needed more to do and more staff.

Three people we spoke to during the morning of our inspection complained to us that they felt cold. One person invited us to, "Come and sit in the gale with me." Care staff seemed unaware of the impact of leaving the door open every time they went outside.

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

Care records we looked at contained up to date and complete daily communication records for the person concerned. They also contained contact details of other professionals involved In the person's care and a record of any contact with these professionals. None of the care records we looked at contained any evidence of the person and/or their representative being involved in reviews. The reviews we looked at were signed only by a member of care staff. The reviews that had taken place were often found to be recorded with only brief entries, for example 'no change,' with no further evidence of any discussions detailed in the care records. The 'memory and cognition' section of one care record we looked at had been reviewed monthly with no changes recorded since the section was completed when the person moved into Royal Court over 18 months ago. However, this information did not correlate with what we observed and we were told there had been significant changes in this person's memory and cognition.

Most of the care records we looked at contained a 'life story book.' These held varying amounts of personal information regarding the person concerned. This was the main record on file that gave a sense of the person's social history and what they liked and disliked. Some had significant gaps in information. The registered manager told us 25 of the 28 people living at Royal Court had a life story book within their care record. As far as the three people who did not have a life story booklet completed, we were told there were letters in each of their files to their relatives confirming that a life story book had been sent to them with a request for completion, which they had declined to do. No other efforts had been made to obtain this information for these three people or complete some of the gaps in other people's life story books.

This continued to be a further breach of Regulation 9, Person-centred care. In addition by failing to maintain an accurate, complete, contemporaneous record in respect of each service user this also continued to be a breach of Regulation 17, Good governance.

The registered manager told us they operated an 'open door policy.' This meant people living at Royal Court, their relatives and staff working at Royal Court could approach her with any concerns or queries at any time. A relative told us about the registered manager, "She is brilliant, really good." People living at Royal Court told us the registered manager was approachable, "[Name of registered manager] is always around Monday to Friday, couldn't wish for a better manager, door is always open."

There was a complaints policy clearly displayed in the reception area. It gave details of who to contact to make a complaint and who to contact if you were unhappy with the original response. In the previous 12 months CQC had not been notified of any complaints by the registered manager and she confirmed that she had not received any complaints at all in at least the last 12 months. The registered manager had met with one family to discuss CQC's previous inspection report and she showed us a written record of this meeting.

Our discussions with people and their relatives had brought up several concerns regarding the lack of activities and low staffing levels, there was no record of these issues ever being raised with the registered manager. People told us they did share their concerns with staff. These concerns were not recorded anywhere. This means improvements were still required in order to identify and act upon complaints in a way to resolve issues.

Inadequate

Is the service well-led?

Our findings

We checked progress the registered manager had made following our inspection on 9 and 14 September 2015 when we found the service had not assessed and monitored effectively and in a way to identify and make improvements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

We were shown the responses from a quality assurance survey sent out to relatives or friends of people living at Royal Court and to one person who lived there in April 2016. 13 responses were received. The main areas of concern were in response to the questions, 'How would you describe the standard of accommodation,' and 'How would you rate the activities carried out at Royal Court.' There was no analysis of the results of this questionnaire and no evidence of any actions being taken as a result of the concerns raised. There was an audit undertaken in November 2015 of the previous quality assurance survey in October 2015. The associated action plan identified that improvements were required regarding re-decorating and more activities being made available. Against these actions it was written 'improvements made and ongoing.' There was no further detail.

There was no record of any staff or resident quality assurance surveys undertaken in the previous 12 months. The registered manager confirmed this hadn't happened.

The registered manager showed us written evidence of resident's meeting that's had taken place in November 2015, January 2016 and April 2016. The agenda and actions from each meeting were recorded. Any actions taken were then recorded at the next meeting. We were told there were no more resident's meetings planned as the registered manager was waiting for the outcome of this inspection.

We saw a meeting with senior care staff had taken place in February 2016. We were also provided with written evidence of a meeting for all staff in December 2015. The notes of this stated these meetings would take place at least every three months. However, there were no further records of any meetings with all staff and the registered manager confirmed this was the case. Again we were told this was because the registered manager was waiting for the outcome of this inspection.

We asked the registered manager what quality assurance audits were carried out at Royal Court. In addition to medication audits we were told the most senior member of care staff also undertook a monthly audit of care records. We asked to see evidence of this. We were provided with a sheet of paper which listed the names of the people living at Royal Court with a tick next to their name in columns for each month. We asked what was actually being looked at during this audit, where this was recorded, and what areas of good practice or areas for improvement were identified. We were told by the registered manager this information did not exist.

We asked the registered manager if she undertook a daily walk round the premises to identify any problems with the premises or equipment and to talk to people about any concerns they may have. We were told this did happen but it was not recorded anywhere. The service's policies and procedures continued to include

an 'Annual Development Plan for Quality Assurance.' This stated the manager and director would do a monthly walk around the premises, speak to people, visitors and staff and document any areas of concern and take action where required. We saw records for 'home audits' undertaken in October 2015, January 2016 and May 2016. It did record what action needed to be taken as result but not whether this had been completed. The home audits focussed on issues with the environment and building maintenance and did not include concerns raised by people living at Royal Court. This meant the service continued not to meet the requirements of its own quality assurance policy.

We were shown the 'accidents and incidents' book. The details of each accident were recorded. However, there was no analysis of this information to look at any patterns or trends to accidents that took place at Royal Court, and therefore no learning as to how to reduce the risk of similar accidents happening again.

We saw the service had a wide range of policies and procedures available to staff. Most had been implemented over 10 years ago; however the content was up to date and relevant to current working practices. This implied they had been reviewed since implementation and therefore reflected current legislation and practice. The registered manager confirmed this was the case.

The service held records of up to date safety checks on small electrical items (PAT tests), equipment service and maintenance, gas safety and fire safety. The registered manager told us that legionella checks were not required as the service's water supply was stored at 60 degrees Celsius, this meant the virus would not be able to survive in this temperature.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that a service displays their most recent rating on their premises and on every website maintained by or on behalf of any service provider. Prior to this inspection we checked the service's website and the rating was not displayed here. We spoke to the registered manager about this who told us the website needed updating. This was a breach of Regulation 20A, Requirement as to display of performance assessments.

Our findings from this inspection identified the governance systems in place to evaluate and improve practice in regard to past breaches of regulation had not been effective. Therefore this continued to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.