Care Quality Commission

Royal Bay Care Homes Ltd

Royal Bay Nursing Home

Inspection report

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30 November 2016

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 29 and 30 November 2016 and was unannounced.

Royal Bay Nursing Home provides care and accommodation, including nursing care, for up to 35 people. There were 30 people living at the home when we inspected. People living at the service were all aged over 65 years and had needs associated with old age and frailty as well as dementia. The service also provides care for people who are at the end of their lives..

The service did not have a registered manager. At the last inspection in January 2016, the service did not have a registered manager and it was unclear then who was managing the service at that time. Since then the provider had not confirmed in writing who was managing the day-to-day operations of the service. Therefore the provider was in breach of the Registered Manager condition of their registration which requires them to have a registered manager in place. 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 provider lacked oversight of the service and there was poor quality monitoring. Some of the concerns found at the previous inspection continued to be areas of concern at this visit. At the last inspection we found the system to assess, monitor and improve the quality and safety of the service was not adequate and we made a requirement for this to be addressed. The provider submitted an action plan to say how they would meet this regulation. At this inspection we found this regulation was still not met. There were shortfalls in how care was coordinated and sufficient action was not taken to ensure people received safe care and treatment. We were concerned about the lack of consistency in the management of the service since the last inspection. Care records were not securely stored.

At the last inspection we found the provider had not ensured people's nutritional and hydration needs were met and made a requirement for this regulation breach. The provider sent us an action plan of how this was to be addressed. At this inspection we found sufficient action was not always taken where people were at risk of malnutrition and dehydration. This is regulation was still not met.

Providers are required to notify the Commission of certain events or incidents affecting service users and the safe operation of services.
At the last inspection we found the provider had failed to notify us that the heating system was not working. At this inspection we found incidents were not always notified to us, namely, a safeguarding investigation being carried in conjunction with the local authority safeguarding team. This regulation was still not met.

At the last inspection, we found the provider had not ensured the home was adequately heated. The provider sent us an action plan of how this was to be addressed. At this inspection, we found the heating was generally working but that one person's radiator did not work which was repaired at the time of the

inspection visit. This regulation was now met.

Whilst some staff told us they were supported and could seek advice when they needed there was a lack of formal supervision of staff and registered nurses.

Sufficient action had not been taken to ensure the equipment in the service was safe. This included a hot water dispenser, supplementary heating in bedrooms and servicing of the portable electrical appliances. Sufficient numbers of staff were not trained in first aid. Medicines procedures were not always safe and people did not always receive the correct medicine.

Care plans and assessments did not always include sufficient detail of how care needs were to be met, including end of life care.

People told us they felt safe at the service. We saw people were clean and appeared well cared for. People, relatives and professionals said the standard of personal care was good. Staff were observed to treat people with kindness and respect. People told us the staff generally treated them well.

There were sufficient numbers of staff but we were concerned that only two registered nurses were employed as part of the staff team.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff and the manager were aware of the principles and guidance associated with the MCA. Where needed assessments of those who lacked mental capacity to consent were carried out and applications made for DoLS.

Records were maintained of complaints and how they were looked into.

Following the inspection we wrote a Letter of Intent to the provider explaining the Commission's concerns about the safety and quality of the service. We asked for an immediate response as to how these matters were being addressed. The provider responded as requested explaining actions they were taking to address the most immediate concerns but action was still needed to improve the overall safety and quality of Royal Bay Nursing Home.
The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including continued breaches from our inspection in January 2016. You can see what action we told the provider to take at the back of the full version of this report.

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.

A safeguarding investigation was not reported to the Commission as required by Registration Regulations.

People did not always receive safe care and treatment because risks to their health and safety were not assessed or mitigated. Risks and action regarding equipment used in the home were not always adequately assessed.

Medicines were not safely managed.

Sufficient numbers of staff were not trained in first aid.

Sufficient numbers of staff were on duty to meet people's needs although there was a heavy reliance on agency nurse staff to fill permanent vacancies.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was provided for staff but there was an absence of formal supervision of staff, including the supervision of registered nurses.

Where people required support with eating and drinking records were not accurately maintained to ensure this need was met and risks managed

Staff liaised with health care services but did not always ensure this took place in all circumstances.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

Is the service caring?

Requires Improvement

The service was not always caring.

Arrangements for end of life care were not always recorded.

There were inconsistencies in how staff treated people with dignity and respect and how people's privacy and choices were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst people's needs were assessed these were not always accurate. There were delays in completing care plans and care plans did not always contain the right information for staff to provide care to people.

Activities were provided to meet people's social needs but these were limited.

There was a complaints procedure and records showed any complaints were looked into.

Is the service well-led?

Inadequate

The service was not well-led.

The management arrangements for the service were not clear and therefore accountability for day-to-day operations was vague.

Systems for assessing, monitoring and improving the quality of the services provided were not sufficient to ensure people always received safe care.

Requests for information from the manager to be provided as part of the inspection were not always timely.

The provider had failed to notify the Commission of the management arrangements at the service.

Royal Bay Nursing 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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 and 30 November 2016 and was unannounced.

The inspection team consisted of an inspector, a pharmacy inspector, a Specialist Advisor in nursing care and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with 15 people and to seven relatives. We spoke with eight care staff, the manager, the deputy manager, a registered nurse and the chef. We also spoke with two community nurses who gave their permission for their comments to be included in this report.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for seven people as well as the records of medicines

administered to people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Staff records were reviewed, which included checks on newly appointed staff and staff supervision records.

Inadequate

Is the service safe?

Our findings

At the inspection on 19 and 20 January 2016 we found the provider was in breach of Regulation 15 as the hot water and heating system was not working properly and people had limited hot water and heating. The provider submitted an action plan to say this was repaired. At this inspection we found the heating was working and the home was warm. However, we identified a radiator in one person's bedroom did not work and the maintenance person attended to this. We were also aware the hot water and central heating had not worked properly in the period since the last inspection as we received complaints about this. The manager confirmed there had been recent problems with the hot water and heating which were now resolved.

Staff were trained in the safeguarding of people and said they would report any safeguarding concerns to their manager. There were assessments for each person regarding their 'vulnerability' to risks and ability to use the call bell, which highlighted where people may need additional monitoring. Not all staff were aware of who they could contact outside the home if they had concerns which fell within the scope of a safeguarding incident. The service had policies and procedures regarding the safeguarding of people at risk. However, we found the management of the service were currently investigating a safeguarding concern on behalf of the local authority, which was not notified to the Commission. The regulations require that the provider notifies the Commission of any abuse or allegation of abuse to a person. This is a breach of Regulation 18 of the (Registration) Regulations 2009.

People and their relatives gave mixed views regarding safety and care at Royal By nursing home. One person said, "I can't fault anything here – I am very well looked after." However, another person described the night staff who were agency staff as "a bit rough" and didn't always answer the call bell promptly, indicating this needs to be explored more by the home's management. Relatives gave mixed views about safety in the home. Three relatives described the staff as providing safe care whereas two others said it was not. These included a reference to two occasions when safe moving and handling was not provided and the other relative said appropriate medical care was not always sought .

The provider told us the portable electrical appliances were last tested in 2012 when some of these should be checked annually. Electrical equipment has therefore not been tested in line with guidance to ensure it was safe to use.

A hot water dispenser was situated in the conservatory for people and visitors to make hot drinks. The water was very hot and could easily scald. There was no risk assessment to check if there were risks to people or visitors from the scalding hot water as people living with dementia were able to access the water dispenser and may not always be aware of safety risks. Supplementary heaters were used in bedrooms including electric convector heaters. There were no risk assessments to determine what risk these posed to people from possible burns or the risk of fire. There were no recorded measures in place as part of a risk assessment to mitigate these risks to people and the manager confirmed these risks were not assessed. Following the inspection the provider confirmed immediate action was taken to ensure this equipment was safely used. We identified the first aid kit on the first floor contained out of date steripods, dressings and gloves. The

premises and equipment were not adequately serviced and maintained.

Whilst risk assessments were carried out regarding aspects of people's care (including moving and handling and use of bed rails), adequate steps were not always taken to accurately assess the risks to people and to mitigate those risks. Care and treatment was not always provided in a safe way to people. For example, one person's daily care records identified the person had a white discharge with an odour from their genitals. A member of the care staff team stated in the records that this was reported to one of the nurses. There was no record of any follow up for this or any decisions being made as to whether the person needed to be seen by a GP. When this was raised with the manager, she was unaware of the record and event. The staff had failed to act to ensure this person's medical needs were addressed and to make the necessary arrangements for their medical care. One person's risk assessment regarding diabetes was contradictory and recorded, 'does not have diabetes' in one section. Then in another section it stated, 'to ensure diabetes medication is given, to monitor signs of hypo and hyperglycaemia, to ensure feet are checked daily, to liaise with the diabetic nurse, to liaise with the dietician.' At the end of the assessment it stated, 'does not have diabetes.' Therefore it was not clear what the person's current condition was and how risks of diabetes were to be managed.

Assessments and care plans regarding the management of pressure areas on people's skin were inconsistent and records showed procedures were not always followed as set out in pressure area care plans. This placed people at risk of not receiving the right care to treat pressure areas on people's skin or to prevent pressure areas developing. For example, one person's assessment said they did not need an air mattress to alleviate pressure areas on their skin but we found they did have an air mattress. We asked the manager if the person needed to be repositioned or turned by staff. The manager replied, "No he/she doesn't need turning. He/she turns himself/herself." This person's daily records referred to them being turned every four hours and there were charts to show they were turned every four hours from 8pm each night. This was not recorded in the care plan to ensure this was done consistently. Whilst the person was being assisted by the provision of an air mattress and being repositioned by staff, the lack of consistency in the assessment and care planning meant there was a risk the person may not get the care they needed to prevent or alleviate pressure sores. We also identified this person's air mattress was set at the incorrect pressure according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. Another person was identified as having pressure areas to their skin and there was a referral to the Tissue Viability Nurse for assessment, advice and possible treatment but this had no date on. The Registered Nurse on duty did not know the date the referral was sent. There was no evidence the referral was followed up. The care plan stated the person needed to be turned every three hours but the charts showed this was taking place every four hours. A community nurse told us care plans regarding wound care were not always updated and that turning/repositioning charts were not always not completed as set out in care records. The community nurse gave an example of one person being turned at 9am and then not again until 3pm. Sufficient action was not taken to ensure treatment and care was followed up as identified. The management of pressure areas was not consistent with the care plans to ensure people were safely treated and managed.

We identified that insufficient numbers of staff were trained in first aid. During the week commencing 21 November 2016 there were two nights where there were no staff on duty who were trained in first aid. There was a defibrillator in the home, but staff said they did not know how to use it and had not received training in using them. The manager said staff were trained in using the defibrillator but there were no records to show this had taken place and this did not reflect what staff told us. The provider had not ensured that staff had the skills and competence to provide safe care and treatment.

During our inspection, we looked at the systems in place for managing medicines. We spoke to staff involved

in the governance and administration of medicines. We looked at seven medicines administration records (MARs) in detail and the prescribing of sedating medicines on 16 further MARs. We looked at the procedures for the handling, ordering and administration of medicines.

Medicines were stored securely in the locked treatment room and in locked medicine trollies that were secured to the wall when not in use. We saw seven full oxygen cylinders in the treatment room that were free standing. In accordance with good practice guidance, medical gas cylinders should be stored in a way that prevents them falling over or causing injury. Staff recorded the maximum and minimum fridge temperatures daily. However, the maximum temperature was recorded between 10 and 14°C every day from 28 February 2016 to 29 November 2016. This is outside of the specified temperature range (2 - 8°C) for refrigerated medicines. The nursing staff were not clear what the maximum temperature should be and had not taken any action in response to the high temperatures. Storing medicines at a temperature warmer than the manufacturer's recommendation can affect the potency and effectiveness of their active ingredients.

It was not always possible to check that people were getting their medicines as prescribed because the service kept poor or inaccurate records about their stocks and administration. We saw that staff recorded people's medicines administration on the MARs, but some MARs were not completed accurately and contained gaps. While staff accurately recorded patch application details, it was not clear when and where other topical products were applied. The pharmacy supplied topical medicine administration records (TMARs) but staff did not complete these. Staff did not record what medicines had been ordered from the pharmacy and GP and they did not keep a stock balance of medicines received and administered in the service.

Staff told us that when the home received a supply of medicines the stock was checked against the previous MARs. However, we saw one medicine that was not the prescribed product for a person. The staff had not noticed the supplying pharmacist had supplied the wrong product. While medicines in the trollies were in date and suitable for use there was a refrigerated medicine that should have been discarded one month after opening but had been administered to a person for two months after the discard date. Therefore this person was at risk of receiving ineffective medicine because the recommended storage guidance had not been followed.

Staff wrote MARs by hand for people who had did not have a printed MAR supplied by the pharmacy. The handwritten MARs were not always checked for accuracy and signed by a second person. The National Institute for Health and Care Excellence (NICE) recommend that handwritten MARs should be checked for accuracy and signed by trained staff to reduce the risk of errors.

A GP routinely visited the service once a fortnight. While the nurses made notes about the GP visit in the care plans there was not always enough information to clarify prescription details. For example, we saw a course of steroids prescribed for one person but it was not clear when the medicine should have stopped. Following the inspection we received information from the manager which confirmed this person had received in excess of the prescribed steroid in error because the prescribing details were unclear. In addition, an antibiotic eye drop was administered to a person for 17 days which is longer than expected for a short course of antibiotic treatment. We could not establish if this was the prescriber's intention. When medicines are prescribed for 'as required' administration, it is good practice to have protocols to support staff to administer the medicines effectively and safely. The service were not using any 'as required' medicine protocols and therefore it was not clear when this medicine should be given and at what point medicines should be reviewed to ensure they were meeting people's needs.

In 2015 a patient safety alert from NHS England had been released regarding the risk of accidental ingestion

of fluid/food thickeners which had resulted in death from asphyxiation. Therefore care providers should consider how to keep people safe from this risk, including the safe storage of thickening agents. We identified one person living with dementia had a pot of food/fluid thickening powder within reach of them in their bedroom and therefore was at risk of ingesting it. On the day of the inspection, the provider took action to make sure that they followed the actions recommended in the patient safety alert. However, had this not been pointed out during the inspection, the risk of this would have continued.

Training on the safe administration of medicines was not mandatory. Staff did not undergo competency assessments to establish they had the skills to safely administer medicines.

The management had not carried out a medicine audit since February 2016. We were told that the controlled drug stock check should be done weekly but only seven checks had been completed between September and November.

The above evidence demonstrates that the provider had failed to provide safe care and treatment for service users. Risks to people had not been appropriately assessed or mitigated to ensure people's safety. Staff did not have necessary qualifications, competence and skills to keep people safe. Equipment used by the service were not always safe or used in a safe way. Medicines were not managed or administered in a safe way or in accordance with best practice. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will publish the details of our Regulatory action when this has been completed.

Records showed the electrical wiring was checked within the recommended timescales. The hoists and passenger lift were serviced and checked by suitably qualified persons. The manager informed us valves were installed on hot water outlets to prevent people being scalded. The gas heating system was serviced in 2016 and a check of the risks of legionnaire's disease was made in 2016.

We looked at staffing levels at the service. The service employed three registered nurses, which included the deputy manager. However, the deputy manager left the service following the inspection. In order to ensure a registered nurse was on duty at all times the service used agency nurses. For the week commencing 21 November 2016 the staff duty rota showed six shifts were covered by agency nurses. The provider informed us that the service was in the process of recruiting additional registered nurses. We have also commented on the use of agency nurses in the Effective section of this report.

The staff rota showed there were six staff on duty from 8am to 2pm each day and five care staff from 2pm to 8pm. A registered nurse was also on duty at these times. Night time staffing consisted of three care staff and one registered nurse. People and relatives gave mixed views on whether there were enough staff on duty to meet people's needs. Three relatives said there enough staff whereas two other relatives said there were not enough. For example, one relative said staff were overstretched which affected their ability to look after people well, saying, "The staff run around like headless chickens." One person said staff were sometimes slow to respond when they asked for help by using the call point in their room whereas other people said staff responded immediately. A relative said staff sometimes didn't get their next of kin up until 12 noon due to staffing pressures. Staff said they considered there were enough staff to meet people's needs and on the days of the inspection we observed there were enough staff to provide the right care to people in a timely way. We observed there were sufficient numbers of staff to meet people's needs at the time of the inspection, although there was a high reliance on the use of agency staff to fill permanent vacancies, particularly for skilled nurses.

We looked at the staff recruitment procedures. References were obtained from previous employers and

checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of staff being interviewed to assess their suitability for the post. Staff said their recruitment involved an interview and reference and a DBS check. Records showed that the nurse agency had made appropriate checks on the agency nurses supplied to the service.

Requires Improvement

Is the service effective?

Our findings

At the inspection on 19 and 20 January 2016 we found the provider was in breach of Regulation 14 as records did not show people were receiving adequate nutrition and fluids. The provider submitted an action plan to say how this would be addressed and the regulation met. At this inspection we found arrangements for ensuring people received adequate food and fluid were still in need of improvement.

Care plans and records did not always show the risks of malnutrition and dehydration were adequately addressed. Nutritional assessments called a Malnutrition Universal Screening Tool (MUST) were used to assess those at risk of malnutrition. We saw how one person had lost weight whose MUST assessment indicated they needed to be referred to a dietician for advice. This was done on 23 September 2016 via the GP. There was no response to the referral and the manager confirmed this was not followed up. This person was prescribed a food supplement and records showed this was given. Care plans did not include any guidance about fortifying the person's diet to increase the calorific value. A food and fluid chart was maintained for this person, which showed they did not always receive adequate fluids. The total daily fluid intake was not recorded so staff could monitor this. On some days we saw the person received approximately 1000ml of fluid but on one day received only 320ml and another of just 450ml. This placed the person at further risk of malnutrition and dehydration.

For another person, the MUST score was 2 which also indicated a referral to a dietician was needed. There was no record of this being made. There was evidence the person had been reviewed by the GP and staff said the person was prescribed supplements by the GP. The care plan stated the person 'needed approximately1400 ml fluid daily. Any deterioration in diet or fluid intake to be reported to Sister.' We looked at fluid charts for six days. The highest intake was 950ml and on two occasions was less than 500ml. There was no record of any follow up for this to ensure the person was drinking enough. Fluid charts did not include any measurement of fluid output to ensure they received adequate hydration. Whilst most relatives we spoke to said the food was good, one relative said the staff had been "slow to act" in obtaining food supplements and did not think people were always supported adequately to eat. Sufficient action was not taken to mitigate the risk of malnutrition and dehydration.
This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will publish the details of our Regulatory action when this has been completed.

People told us they liked the food. For example, one person told us, "The food is very good. There's always a choice." Another person said, "The food is out of this world." People said they were given support to eat where they had difficulties, such as in cutting up food. Relatives were also complimentary about the food. For example, one relative said the food was good and when food was liquidised it was prepared so the person was able to taste each part of the meal. We spoke to one of the chefs who said there was a menu plan and that each person was asked in advance what they would like from a choice which was recorded. The chef said meals were home made from fresh ingredients and that ingredients such as cream were used to increase the calorific value of food when needed. We observed the lunch served in the dining room as well as staff helping people to eat in their rooms. People were supported well by staff to eat their meal. People were able to have wine or beer with their lunch. Drinks were available to people in their rooms and in the

communal areas.

We looked at the training and support provided to staff. Whilst staff said they were able to ask for advice and support there was a lack of formal recorded staff supervision. One staff member said they did not have supervision and did not always feel supported, whereas another said they felt supported and said there was always a senior care staff member or nurse available for advice. We observed a member of the care staff team consulting with the management team and gaining advice regarding a person's care. Staff also had group supervision sessions where they discussed relevant care topics. We looked at records for four staff; each had a Performance and Development Review. One staff member had a meeting where their worked was discussed in March and May 2016. There were no records of supervision for any of the three nurses employed although there were records of annual Performance and Development Reviews. The deputy manager who was the clinical lead for the service had not had a Performance and Development Review or formal supervision. Therefore, the competencies and knowledge of staff were not being routinely supervised or checked to ensure staff had the right skills and experience to support people.
The service's management maintained a spreadsheet record of training courses considered mandatory which were renewed at intervals. These included subjects such as moving and handling, fire safety, safeguarding people, infection control, dementia care, diet and nutrition, continence care and end of life care. The spreadsheet showed some subjects such as safeguarding training, continence and pressure area care, diet and nutrition and first aid had not been provided or needed to be updated. For example, according to the training matrix 21 care staff had not completed the mandatory training in adult protection. The manager said this was being addressed and this was being monitored via the training spreadsheet to ensure staff received training updates. .
This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed three registered nurses, one of whom was the deputy manager. As a result, the service was heavily reliant on agency staff to cover nursing vacancies. Agency nurses were used for six shifts for the week commencing 21 November 2016. We were concerned that, as a result of this, nursing procedures were not coordinated well and information not always communicated so there was consistency. In addition, the inconsistent or inaccurate information recorded in care records (as referred to in other parts of this report) meant that agency staff or new staff unfamiliar with people's needs may not be able to deliver care effectively to meet them. Following the inspection, we were told the deputy manager had left the service, which meant there were just two registered nurses on the staff team. The provider confirmed there was a drive to recruit registered nurses.

People made generally positive remarks about the skills of the staff. For example, one person said, "The staff are excellent, the nurses are very good." Another person said all the staff were "good" and made specific reference to all of the staff who worked in the home.

Newly appointed staff completed an induction, which involved a period of 'shadowing' more experienced staff. We spoke to a member of staff who had been recently recruited and would shortly be 'shadowing' other staff. We saw an induction booklet for a registered nurse who had recently started work at the service. One staff member said the induction was not sufficient and consisted of being shown around the service and 'shadowing' other staff for three shifts before working independently.

The provider told us nine of the 22 care staff were trained to National Vocational Qualification (NVQ) level 3 and a further four staff at NVQ level 2. Two care staff had registered to complete a level 2 Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required

standard. Records showed there was additional training for nurses such as procedures for intravenous procedures.

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 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).

The service had policies and procedures regarding the Mental Capacity Act 2005 and the associated Code of Practice. This legislation and guidance protects those who do not have capacity to consent to their care and treatment. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations are made by the local authority for those who do not have capacity to agree to their care and treatment and have their liberty restricted for their own safety. We saw people's capacity was assessed where needed and application for a DoLS authorisation made to restrict people's liberty where they were not able to consent to residing at the service. We observed staff asked people how they wanted to be helped and explained to people how they were supporting them.

Records showed people's health care needs were monitored such as blood pressure and body temperature. There were records of liaison with health care professionals such as the GP, community nurses and tissue viability nurses. However, we have highlighted in other parts of this report where we had concerns about timely follow up on referrals, seeking appropriate advice regarding tissue viability and obtaining clear instructions for medicines prescriptions.

Requires Improvement

Is the service caring?

Our findings

People told us the staff generally treated them with kindness. People said the staff were friendly and they got on well with them. For example, one person said, "The staff are all very kind. We have a laugh together." Relatives were also complimentary about the approach of staff to working with people. For example, a relative described the staff as, "Friendly, very kind and know our mother's needs well." Another relative said, "The staff are wonderful and caring."

People said they were able to choose times they go to bed and get up in the morning as well as how they spent their time throughout the day. However, one person complained that staff had woken and dressed them at 0530am which was too early for them. This person said they went back to sleep in their chair fully clothed as it was too early. Details of the person's preferred time for going to bed was recorded but not for getting up in the morning. The daily records made by staff did not detail the times staff got this person up in the morning. This was discussed with the manager and we asked them to review and acknowledge people's preferences in relation to their morning routine. The manager also said this person had decided to get up at this time.

We observed staff interacted well with people. For example, during lunch staff spoke to people politely and smiled. Staff knew people's names and what food people preferred. Staff made eye contact with people and checked with people before providing assistance. We did, however, notice one interaction where two staff supported someone to position themselves by arranging cushions but did not speak to the person to say what they were doing but spoke instead to one another. When one of these staff returned a minute later they did speak to the person and communicated what they were doing.

People said their privacy was acknowledged and respected although we observed one person was not happy that their bedroom was being used by an outside contractor to service the hoists. Staff had not taken action to ensure this person's privacy was always promoted.
Although the majority of interactions we observed, or, were told about reflected a caring approach by staff, there were other examples which did not demonstrate this. This was an area requiring further improvement to ensure a consistent approach by staff.

The service provided end of life care to people. A relative of one person who was at the end of their life described the care as good and said arrangements were being made for a priest to visit them. Staff said people's end of life care needs were met but one staff member said there was not enough time to do this in the way they wanted, adding, "I could make such a difference to them if I could spend that extra time with people." A member of the health services team who commissioned care at the service told us advanced care plans for end of life care had not been completed where two people were admitted to the service for this reason. At the inspection, we also found one person who was receiving end of life care did not have an end of life care plan. This meant staff did not have guidance in order to provide care which reflected the person's individual needs and preferences. For another person we saw there was an end of life care plan. There was a lack of detail in care plans about the emotional support for people who were in receipt of end of life care. Health care commissioners told us the service was accredited with the National Gold Standards

Framework in End of Life Care but added there was little evidence of this. The National Gold Standards Framework in End of life Care is an evidence based approach to optimising End of Life Care and involves distance learning training for staff. We have identified the lack of accurate and person-centred information in care records as a breach of Regulation in the 'Responsive' domain of this report.

People said their independence was promoted. For example, one person said how they looked after themselves and that staff supported them with this. Care plans included details of those aspects of personal care which people could do for themselves.

Staff demonstrated they had values of compassion and respect for the people they looked after. For example, one staff member said they treated people as they would one of their family. Another staff member said, "On the whole the care staff do care and that is the main thing but more time is needed to give the best care." Staff said they were fond of people and tried to provide the best care they could.

The manager told us people's religious needs were catered for by the provision of holy communion once a month.

Requires Improvement

Is the service responsive?

Our findings

There were examples of assessments and care plans giving staff sufficient information about care needs. We also found examples of wounds being monitored, which demonstrated people recovered. However, we also found assessments and care plans were not always completed in enough detail to ensure people's needs were met. For example, the provider's own audits identified one person was admitted to the service and 17 days later did not have a care plan. Health service commissioners told us one person was resident at the service for three weeks respite care but no care plan was completed in that time.

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There was evidence that care plans were inconsistent and did not accurately reflect the care being provided, such as the prevention of pressure area care in the Safe section. Care plans did not always include enough detail to show what action staff should take. For example, one person's care plan regarding their dementia care said, 'Try to reduce confusion in an environment that meets the needs of the individual by orientation in aspects of daily living.' There was no guidance for staff about how and when this was to be achieved or what was to be provided. Another person's care plan did not show the person's preferences for getting up in the morning were acknowledged. The assessment and design of care for people was not adequate to ensure people's needs and preferences were always met. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the care they received and said the standard of care was good. People also said care was provided in the way they wanted. We observed people were clean and well presented. Health care professionals described the standard of personal care as good and that care plans were sufficient to give staff guidance in this but not for more complex needs. Relatives were also generally positive about the standard of care. For example, one relative said, "On the whole the care is pretty good," and gave an example of people being well cared for. One relative was not satisfied with the standard of care provided by the home and gave examples of a lack of promptness to take action regarding nutrition needs and seeking medical attention.

People said there were activities they could attend if they wished. For example, one person said, "There's plenty to do. I'm always included. I like the quizzes." Another person said there was a programme of activities. Another person said they liked to stay in their room and to read their daily newspaper or a book. We saw several people had a daily newspaper. We observed one person helping staff to prepare the dining tables for lunch and other people spent time in the lounge or conservatory. On the days we inspected we

saw little activities being provided and this is an area the service needs to improve on. There was an activity notice board, which displayed just two activities for the week the inspection took place in: a gift day and a 'dress down' day. The notice board included details of a Christmas fair taking place in December. We were informed by the manager that a Christmas raffle was due to take place. Outings were arranged for people and we saw a photograph display of people visiting an aviation museum in the spring.

People and their relatives gave us mixed views on whether their concerns were addressed. One relative said, "The management listened and acted when we raised something." Another person said, "The manager sorts out any problems and always comes and helps." However, one relative felt their concerns were neither listened nor responded to. This relative said that when they raised concerns the management's response was "bullish" and added their concerns were not addressed.

The complaints procedure was contained in the service's Statement of Purpose and was displayed in the hall. People said they knew would speak to the manager if they had a complaint. We were shown the record of complaints, which included evidence they were looked into. For one of these there were records to show the complaint was investigated by the management and staff but there was no record of any response to the complainant. The records and discussion with the deputy manager showed the provider did not consider the complaint was valid but there was no evidence of any response to the complainant to say so.

Inadequate

Is the service well-led?

Our findings

At the inspection on 19 and 20 January 2016 we found the provider was in breach of Regulation 17 as the systems used to asses, monitor and improve the quality of the service had not identified and addressed concerns. The provider submitted an action plan, which said external monitoring of the service was to be implemented. At this inspection we found the service had audits and checks by the management and provider but these had failed to identify the concerns we identified at this inspection. Audits of care plans had failed to identify omissions in assessing and care planning for nutrition, pressure area care, end of life care and that people got the medical help they needed. There was a lack of an effective system to ensure medicines procedures were safe and that any medicines errors were looked into and addressed. The quality assurance system had not ensured sufficient numbers of staff were trained in first aid and that all staff received adequate supervision. In addition, the provider's quality monitoring systems had failed to make sufficient improvements since our previous inspection which resulted in the overall rating deteriorating from "Requires Improvement" to "Inadequate" and multiple, persistent breaches of Regulation.

People's and relatives views were sought by way of surveys. We saw 10 recent survey responses which did not have a date. Three surveys said they were not satisfied with the nursing care and two people said they were not treated as an individual. There was no analysis, action plan or follow up regarding these comments. The feedback given by people and relatives had not been used to continuously evaluate and improve the service at Royal Bay Nursing Home.

Records and information about people were not always secure and confidentially stored. This included people's medicines administration records and details on display in communal areas regarding people's personal care needs.

There was evidence of a lack of coordination and responsiveness from the management team at the service. For example, information was not always provided to the Commission in a timely way as requested. At the end of the first day of the inspection the pharmacy inspector raised concerns about the safety of medicines procedures, which needed immediate action. We did not receive confirmation these issues were addressed until we reminded the manager. We asked the manager to look into concerns raised by a relative but did not receive either a full or timely response. The inconsistencies in care reflected a service that was not well-led. The provider had not ensured there was an adequate system to assess, monitor and improve the quality of the services provided as well as the risks to people. The provider had not ensured security of people's confidential records. The provider had not sought or acted upon feedback from relative persons to ensure a good quality service for people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 'We will publish the details of our Regulatory action when this has been completed.

At the inspection of 19 and 20 January 2016 the management of the service was unclear and remained so at this inspection. There was no registered manager. The previous registered manager had cancelled their registration with the Commission but continued to work as the deputy manager. There was a 'head of care' but it was unclear which responsibilities the head of care and the deputy manager had. We were concerned

the service has been without clear management for 11 months and the impact this has had on the consistency and standard of service provided to people. At this inspection the deputy manager was in post and there was a new manager. The new manager described her role as "interim" and was undecided as to whether she would continue in the role of manager over a longer time period. The Commission has not received a notification as required by the Regulations regarding the arrangements for managing the service even after being reminded of this. The provider had not notified the Commission in writing of the changes in the management at the service and the name of the staff member who managed the regulated activities. This was in breach of Regulation 15 Care Quality Commission (Registration) Regulations 2009.

The deputy manager had responsibility for coordinating nursing care but left the service after the inspection. The new manager informed us one of the registered nurses now had responsibility for taking a lead role in coordinating nursing care but this was not always clear as the manager also described this nurse's role as supporting her to complete nursing care plans as she was not a registered nurse. Health care professionals told us they were concerned that the manager was making decisions about nursing care when she was not a registered nurse. The service has been without a registered manager since January 2016 which is in breach of their registration conditions.

Relatives and people gave us mixed views about the management of the service. Two relatives were unsure who the manager was and said there was no manager but there was an assistant manager. These same relatives said the management were approachable and dealt with any concerns raised. Another relative said their concerns were not dealt with by the manager and said they were spoken to abruptly. Staff, however, described the service's management as helpful and they know who to report to regarding any queries they had.

Records were maintained when people fell or had an accident. Each accident or fall was reviewed and changes made to people's care plans to prevent a reoccurrence. There was a record of all falls occurring in the service so the manager could monitor any trends and take appropriate action to reduce further incidents.

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 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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 The provider had not ensured that care and treatment met the needs and preferences of people. This included failing to ensure needs were always assessed and that the design of care and treatment met service user's needs and preferences. 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff received appropriate training, support, and supervision. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the risks to service users were adequately assessed and action taken to mitigate the risks. The provider had not ensured staff always had the required qualifications to provide safe care. The provider had not ensured medicines were safely managed. The provider had not ensured equipment was safe for people to use. 12 (1) (2) (a) (b) (c) e (g)

The enforcement action we took:

Warning notice to be issued for the following:

The provider had not ensured the risks to service users were adequately assessed and action taken to mitigate the risks.

The provider had not ensured staff always had the required qualifications to provide safe care.

The provider had not ensured medicines were safely managed.

The provider had not ensured equipment was safe for people to use.

12 (1) (2) (a) (b) (c) e (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured the nutritional and hydration needs of service users were met. This is a repeat of a requirement made at the last inspection.

14 (1) (4) (a)

The enforcement action we took:

Warning notice to be issued for the following:

The provider had not ensured the nutritional and hydration needs of service users were met. This is a repeat of a requirement made at the last inspection.

9 (1) (a) (b) (c) (3) (a) (b)

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 RA Regulations 2014 Good governance The provider had not ensured there were systems to assess, monitor and improve the quality and safety of the services provided. This is a repeat of a requirement made at the last inspection. Care records were not always secure.

The enforcement action we took:

Warning notice to be issued for the following:

The provider had not ensured there were systems to assess, monitor and improve the quality and safety of the services provided. This is a repeat of a requirement made at the last inspection.

Care records were not always secure.