Roberttown Care Home Limited

Roberttown Care Home Limited

Inspection report

98 Church Road
Roberttown
Liversedge
West Yorkshire
WF15 8BE

Tel: 01924411600

Date of inspection visit:
29 June 2017
04 July 2017

Date of publication:
26 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Roberttown Care Home took place on 29 June and 4 July 2017. We previously inspected the service on 16 December 2015; we rated the service Requires Improvement. We found the registered provider was not meeting the regulation relating to safe care and treatment. On this visit we checked to see if improvements had been made.

Roberttown Care Home provides care and support to older people, some of whom are living with dementia. The home has a maximum occupancy of 29 people. On the days of our inspection 28 people were living at the home.

The service had 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.

During this inspection, we identified the service was breaching regulations related with safe care and treatment, staffing and good governance.

People told us they felt safe and staff were aware of the importance of reporting any concerns to more senior personnel.

Care plans contained a variety of risk assessments although they did not all contain adequate detail to ensure all aspects of peoples care and support were safe. Where people had an airwave mattress on their bed there was no information recorded as to what the setting should be to ensure they were effective. We identified two mattresses that were not set correctly.

External contractors were used to service and maintain equipment. A number of internal checks were also completed, but checks on the emergency lights had not been recorded as completed since February 2017 although we were assured this was a recording error.

There were systems in place to reduce the risk of employing staff who may not be suitable to work with vulnerable people. Staff were continually busy and did not have time to sit and chat with people or with us as part of the inspection process. We saw people were left unsupervised and their needs were not always met in a timely manner.

An electronic system of managing and recording the administration of medicines (EMAR) had been recently introduced. We found medicines were stored safely and staff administered them in a caring and attentive manner. We identified one incident where staff had failed to follow the registered provider's policy in regard to the safe administration of controlled drugs. We also identified discrepancies with the prescribed instructions for the application of creams and the records of administration.

New staff received an induction which included orientation to the home, training and shadowing of more experienced colleagues. Staff received on-going training and supervision. However, not all training may be fully effective as we observed an incident with a person where staff did not identify an escalating situation and only acted when an incident occurred.

We found not all mental capacity assessments were decision specific and the recorded evidence of the assessment process was not specific to the decision which was being assessed. We have made a recommendation about mental capacity assessments.

People were offered a choice at breakfast and lunch. At tea time, although soup was on the menu, we did not see it being offered to anyone. Peoples nutritional risk was assessed and action taken where weight loss was identified. Food records were completed, but they did not evidence the amount of food provided to people.

People had access to external healthcare professionals.

People told us staff were caring and kind. Staff encouraged people to make choices about their daily lives and retain their level of independence. Staff were aware of the need to maintain people's privacy, dignity and confidentiality, however, we saw examples where one person's dignity was potentially compromised and peoples care records were not stored confidentially. Where people had entered the later stages of their lives, records failed to capture how people wanted to be cared for and supported. We have made a recommendation in regard to end of life care planning.

There were a range of activities for people and details of the weekly activity plans were on display at the home.

Peoples care plans were person centred, but they did not always reflect people's current needs and were not always sufficiently detailed. Where people exhibited specific behaviours, their care plans did not detail how staff should support them and we found one person did not have care plans in place for key aspects of their care. Staff recorded when people had been assisted with their hygiene needs but the records did not enable us to establish whether they had had a bath or a shower.

People were aware of how to complain and the registered manager recorded and responded to complaints.

Staff told us they enjoyed working at the home. A range of audits were completed at the home on a regular basis. The registered manager compiled a monthly report which recorded a variety of information relating to the day to day running of the home. A senior manager regularly visited the home and also audited the quality of the service people received. Feedback was gained from staff and people who lived at the home, this included regular meetings and feedback surveys. However, these systems of governance had failed to identify the issues we have evidenced within our report.

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

Requires Improvement

Not all aspects of the service were safe.

Where people required pressure mattresses we could not evidence they were set correctly.

Staff were recruited safely.

Improvements were needed to the management of topical medicines.

Staff did not have time to sit and spend time with people other than part of a task related activity.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff received on-going training and supervision.

Evidence of the assessment of people's capacity was not specific to the decision being assessed.

People were offered a choice of food and drinks.

People had access to external healthcare professionals as required.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

People told us staff were caring and kind.

People were encouraged to make decisions about their daily activities and retain their independence.

We raised two concerns with the registered manager where people's privacy and dignity may have been compromised.

People's records were not stored confidentially.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

There was a range of activities provided at the home.

Care plans were not always an accurate reflection of people's current needs and did not always provide sufficient detail.

Complaints were recorded and responded to.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

There was a system of regular auditing in place, but this had been ineffective in ensuring people received safe, effective and responsive care.

The home had a registered manager in post.

Regular feedback was gained from people, relatives and staff.

Roberttown Care Home Limited

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 29 June 2017 and was unannounced. An unannounced inspection is where we visit the service without telling anyone. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in caring for an older person. One inspector also visited the home again on 4 July 2017. This visit was announced and was to ensure the registered manager would be available to meet with us.

Prior to the inspection we reviewed all the information we held about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

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 improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with eleven people who were living in the home and one visiting relative. We also spoke with the

registered manager, deputy manager, two senior care staff, the activity organiser and five ancillary staff. We reviewed four staff recruitment files, eight people's care records and a variety of documents which related to the management and governance of the home. Following the inspection we spoke with a further three care staff on the telephone.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes, I feel safe here." Staff also told us they felt people were safe. Staff were able to describe different types of abuse and told us they would report any concerns to a more senior staff member. One staff member said, "I'd speak with [registered manager] or [deputy manager]. I'd go above them if I needed to." The registered manager told us any safeguarding concerns were reported to either themselves or the deputy manager who then informed the local authority safeguarding team of the relevant information. This showed staff were aware of how to raise concerns about harm or abuse and recognised their responsibilities for safeguarding people who lived at the home.

Each of the care plans we reviewed contained a variety of risk assessments; for example, moving and handling, falls and skin integrity; we saw each of the risk assessments had been reviewed on a regular basis. However, we reviewed the care plan for a person who had recently been admitted to the home. Staff had completed some risk assessments, for example, medication, nutrition and choking, but others were blank. This included an assessment of their skin integrity and moving and handling. This meant not all aspects of their care had been robustly assessed.

Some people had an airwave mattress on their bed to reduce the risk of them developing pressure sores. To enable the mattresses to function effectively it needs to be set according to the weight of the individual. We looked at two peoples care records but found no information to tell us what the correct setting for their mattress should be, we asked two members of staff, but they were unsure. We saw the mattresses were set at 90kg for both individuals but when we checked their most recent weight, this was recorded as 41.6kg and 48kg respectively. We checked a third person, but we saw the mattress pump was against the bedroom wall. This meant that staff would be unable to easily see the setting to ensure it was set correctly. We brought this to the attention of the registered manager.

At our inspection on 16 December 2015 we found the information relating to moving and handling lacked detail; at this inspection we found improvements had been made. For example, we reviewed the care plans for three people and found detailed information about their moving and handling needs, including use of wheelchairs and accessing the bath or shower. However, one person required the use of a hoist and spent time in a specialist seating chair. Their care plan and risk assessment did not record which hoist or sling staff should use and there was no risk assessment in place regarding the safe use of the specialist chair which we saw them using. This level of detail is important as it reduces the risk of harm to people and staff. However, during our inspection we observed staff supporting people to stand and mobile or transfer using hoists on a number of occasions, these manoeuvres were done safely.

These examples demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were at risk of falls we saw steps had been taken to reduce this risk as well as reducing the risk of injury in the event of them suffering a fall. Some people had bed rails fitted to their beds where they were identified as being at risk of falling out of bed. We also saw where people were at risk of falling out of bed,

but bed rails were unsuitable, they were provided with low beds and crash mats. These reduce the risk of injury to the individual if they fall from their bed.

Accidents and incidents were recorded and we saw evidence they were logged on a monthly report which was submitted to the registered provider. Analysis of accidents and incidents was also completed; this provided an opportunity for staff to identify patterns or trends, thus enabling changes to be made to people's care and support to reduce future risk of injury.

We saw evidence the premises and equipment were serviced and maintained by external contractors. This included checks on electrical wiring, gas safety, fire system and nurse call alarms. We also saw that lifting equipment, for example, hoists and slings had been checked in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We also reviewed the internal maintenance checks, for example, on the fire system and water temperatures. Regular checks had not been signed as completed on the emergency lights since 8 February 2017. When we spoke with the maintenance person we were satisfied by their responses that they were still completing these checks on a regular basis; but it is important to ensure an accurate record of these checks is maintained.

We saw information about the action to take in the event of a fire was displayed within the home and equipment to assist staff should they need to evacuate people from the building was available. Personal Emergency Evacuation Plans (PEEPs) were in people's care plans. A PEEP is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. We compared the information in one PEEP with the same person's moving and handling records in their care plan; the PEEP did not refer to them needing to use a wheelchair. This is important to ensure people can be evacuated swiftly and safely in the event of an emergency.

The registered manager told us they tried to ensure they recruited staff who had the appropriate values for the role, they explained this was more important than the amount of experience they had. We checked staff had been recruited in a safe way. We reviewed four staff recruitment files and found each one contained a completed application form and references had been obtained. Two of the staff had been recruited by the registered manager and we saw their application form evidenced there had been no unexplained gaps in their employment history. Each file also contained a Disclosure and Barring service (DBS) check. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups.

There were insufficient numbers of suitably deployed staff to ensure peoples safety and needs were maintained.

People told us there were not enough staff on duty. One person said, "Staff are so busy. I have to wait for the toilet; I wait that long it's happened." Another person said, "I have a buzzer and they come as soon as they can. I need two (staff) to hoist me, sometimes I've got one (staff) without the other."

One of the staff we spoke with said, "It is hard sometimes obviously." However, staff said they were busy, no-one raised any concerns that people's needs were not met or that they felt unduly pressured by their workload.

We spent significant lengths of time in the communal areas on the first day of our inspection, we observed staff were continually busy and were unable to spend time sitting with people other than as part of a task related activity. People were often left unobserved for periods of time; this put some people at risk of harm.

For example, in the ground floor lounge we observed one person walking around at 8.57am, frequently standing in front of other people. Another person kept asking them to 'sit down and stop bothering people'. At 9.01am the person stood in front of someone who was sat at the table. This person became upset, brandished their cutlery and shouted, "No. Go away." No staff entered the lounge until 9.03am. At 9.19am there were no staff present in the lounge when a person told us they needed the toilet. The kitchen was adjacent to the lounge and we asked a member of the catering team to get a staff member who could support the person to access the toilet. At 9.28am the person said, "I'm desperate, I'm getting very worried about it." No staff had attended to take the person to the toilet and there were no staff in the lounge or the kitchen. We brought this to the attention of the administrator and a member of staff came to attend to them.

At 3.20pm one member of the inspection team walked along each corridor on each floor, including checking the communal areas, but they did not see any staff member until they reached the second floor when they saw a member of staff going through a doorway to go down the stairs.

Later in the day there were no staff available on the first floor between 4.35pm and 4.53pm, there were three people in the lounge and some people in their bedrooms. At 5pm in the ground floor lounge there were 11 people sat in the communal area, but no staff were present in either the lounge or kitchen. On the second day of the inspection there were four people sat in the first floor lounge at tea time, but no staff could be located on the first floor, when we went downstairs we saw four staff were in the kitchen together sorting out the tea time meal.

The registered manager told us they reviewed people's dependency needs and the staffing levels at the home on a fortnightly basis. They said they consistently provided more staffing hours than the dependency tool indicated was required. They said there was a senior carer and four care staff on duty from 7am until 1pm and a senior carer and three care staff between 1pm and 7pm. They were supported by the deputy manager, catering, laundry and domestic staff. However, there were bedrooms on three floors and communal areas on two floors. The registered manager told us five people required the use of a hoist and a further two people needed equipment to assist them to stand up. Where people require the use of a hoist, two staff are required to assist with this manoeuvre to reduce the risk of harm to people or staff. We saw the senior carer was responsible for managing the shift, administering three medicine rounds, supporting with care tasks as well as addressing the needs of visiting professionals and family members.

On the first day of the inspection we asked care staff if they would spend a few moments of their time speaking with us. Despite a number of attempts, this was not possible as staff told us they were busy. Therefore, we spoke with a further three staff who worked in a direct caring role, on the telephone after the inspection. We shared our findings with the registered manager, they told us staff had felt intimidated by the inspectors and the inspection process and had not wanted to speak with us. This was not noted by any of the inspection team and none of the staff we spoke with on the day or afterwards expressed any concerns or worries either verbally or non-verbally.

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

Our inspection on 16 December 2015 found the management of people's medicines was not robust and we found errors in the administration of medicines. On this inspection we found improvements had been made.

The home had very recently changed to an electronic system of managing and recording the administration

of medicines (EMAR). The registered manager and a senior carer said the system was more robust and reduced the risk of errors.

We observed a member of staff administering people's medicines. They had good knowledge of the system despite them only having used it for a few days. They asked people if they wanted pain relief and explained to people what their medicine was for. However, we observed the staff member did not wash their hands prior to the administration of eye drops.

Medicines were stored safely. The medicines room was locked and the temperature of the room and the medicines fridge was checked daily to ensure they were appropriate for the storage of medicines. We checked five individual medicines and found the stock tallied with the number of recorded administrations.

We also checked the management of controlled medicines. These are specific medicines which are classified under the Misuse of Drugs Act 1971 and there are regulations regarding their management and administration. We checked three individual medicines and found the stock tallied with the recorded administrations. However, we saw one entry had not been countersigned by a second member of staff and there was no evidence the stock had been checked since to ensure there were no discrepancies. The registered provider's policy noted 'The process of administering controlled drugs will be undertaken by two appropriately trained and experienced staff following robust recording and administration procedures'. We brought this to the attention of the registered manager, following the inspection, they confirmed a stock check had been completed and no discrepancies had been identified.

Short term topical creams and lotions were stored in the medicine room and were administered by the person who was dispensing the medicines. Other creams, for example, moisturising creams were stored in people's bedrooms and applied by care staff. We found some discrepancies with the EMAR instructions for the application of these creams and the topical administration records (TMAR) completed by care staff. For example, one person's EMAR instructed a cream to be applied 'as directed to affected areas' their TMAR recorded the same instruction, but staff were consistently applying the cream in the morning and evening. A second EMAR instructed staff to apply the cream 'as directed when required to groin'; their TMAR recorded staff were applying the cream in the morning and night. There was a large 'X' in the lunch and tea column to indicate staff were not to apply the cream at this time. This meant the instructions and the recorded administrations were not consistently being adhered to. The home was in its first week of using a new electronic system for the management and recording of people's medicines, however, we raised this with the registered manager, and they told us they would look into this.

On the second day of the inspection we reviewed the medicine audits which had been completed. We saw the issues we had raised on the first day of the inspection had been recorded on the most recent audit as an action which needed to be addressed. This demonstrated the registered manager was responsive and was keen to ensure the best possible outcomes for people living at the home.

We checked the training records for two staff who were responsible for administering people's medicines. We saw evidence they had completed training and an assessment of their competency to administer people's medicines had been completed. This meant people received their medicines from staff who had the appropriate knowledge and skills.

Communal toilets and bathrooms contained ample supplies of soap and paper hand towels. We saw aprons and gloves were also readily available for staff to access. During the morning of our first day at Roberttown we noted an unpleasant odour on a corridor, when we checked two hours later, the odour was still present. We also noted a strong odour in one person's bedroom. We informed the registered manager about this at

the end of the first day of the inspection. When we returned on 4 July 2017 the registered manager told us quotes had been obtained to replace the carpets to both these areas and they were just waiting for confirmation of the date for them to be fitted.

Requires Improvement

Is the service effective?

Our findings

Staff told us new staff received training and also shadowed an experienced staff member before they were included in the staffing numbers for the home. The registered manager confirmed this and said the induction process included orientation to the company, the home and the people who lived there as well as the Care Certificate if the staff member had no previous care experience. We saw evidence new staff had completed an induction in each of the personnel files we reviewed, including, where appropriate, completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life and should be covered as part of induction training of new care workers. However; we noted one staff member had recently changed roles and there was no evidence they had received an induction to support them in their transition of role. Role appropriate inductions prepare staff with support and guidance as they learn about their new responsibilities.

The registered manager told us staff received regular supervision throughout the year and an annual appraisal. Staff also told us they received regular supervision and we saw evidence of this in staff personnel files and on the spreadsheet provided by the registered manager which enabled them to have oversight of all staff supervision dates. Two of the staff whose files we reviewed had been employed at the home for over a year and we saw evidence they had received an annual appraisal of their performance. Regular supervision enables the registered manager to monitor staff's performance and development needs.

All the staff we spoke with told us they received regular training, including moving and handling, infection prevention and control and dementia; we saw evidence of regular training when we reviewed staff personnel files. The registered manager provided us with a training matrix which detailed when staff had completed the individual courses. We saw from this that training was a mixture of e-learning and face-to-face. We also saw the majority of staff training was in date and where courses needed to be refreshed, this was highlighted.

We saw from the training matrix, staff completed dementia training on a three yearly cycle. We asked three staff how they managed people when they displayed behaviour which may be challenging to others. One staff member said, "I would try speaking gently, use eye contact." They told us about a particular person and how they would talk to them about their younger life. The member of staff was knowledgeable about this which indicted they knew this person well. Another staff member said they would, "Give reassurance, allow them to settle and offer them a drink to distract them." They also said they would give the person a sense of space.

On the first day of the inspection we observed an incident where a person was walking around, standing in front of various people until they became focused on one person, grabbing hold of the sleeve of their clothing. A member of staff entered the room and tried to get the person to sit down. When the person grabbed the other person a second staff member also came to assist. The person continued to grab out at the other person and hit staff, staff focused on disengaging the person from grabbing and holding the persons sleeve and then both staff led the person out of the room. While we noted staff remained calm, staff had failed to identify the person's behaviour escalating, therefore preventing an incident occurring, and no

distraction or de-escalation techniques were employed. This showed staff training may not be fully effective.

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 told us they were enabled to make their own decisions. Comments included; "I make my own decisions, I decide", "I can get up and go to bed when I want to" and "No one decides for me, only me."

At our inspection on 16 December 2015 we found that mental capacity assessments had been completed, but they were not always decision specific. On this inspection we reviewed the capacity assessments for five people who lived at the home. We saw that some of the capacity assessments were specific, for example, the use of bed rails and people not being able to manage their own medicines. Others were not, for example, 'regarding DoLS and DNACR'.

We looked at four capacity assessments for one person and saw the content of each document was identical, excluding the decision the document related to. For example; the section 'is the person able to understand the information relevant to the decision' we saw the registered manager had written 'repeat & take time'. For another person the section 'is the person able to retain the information' the registered manager had written 'example my name [person] able to recall a few days later'. These were not specific to the decision being assessed.

We recommend the registered manager seek advice and guidance from a reputable source, regarding MCA assessments and best interest's decision making.

We discussed these issues with the registered manager. They said deficiencies in the process had already been identified and new paperwork was due to be implemented.

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 authorisation procedures for this in care homes and hospitals 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. The registered manager told us seven people who lived at the home were subject to a DoLS authorisation, none of these had any conditions attached. A further ten were awaiting assessment by the local authority.

We saw staff completed training in MCA and DoLS on a three yearly cycle. We asked staff about their understanding of the MCA. One said, "Everyone has capacity unless deemed otherwise." Another staff member expressed understanding of the MCA and why best interest's decision making was relevant to their role.

Where a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney. One of the care plans we reviewed contained evidence the registered manager had checked to confirm a relative did have the legal authority to sign their relatives care records on their behalf.

Most of the feedback we received about the meals at Roberttown was positive. One person said, "The food is good." Another person said, "Sometimes it (the food) is really good and other times it is not as nice."

On the first day of the inspection we observed all three meal times. At breakfast time we saw people were offered a choice of breakfast. One person asked for eggs on toast and this was accommodated. Another person had porridge; the staff member who served them asked if they wanted treacle adding to their porridge. There were six people in the first floor lounge/dining room at 8.44am. One person was sat at the table, but did not have a drink or breakfast in front of them, they told us they had not had anything to eat or drink that morning. A member of staff came in at 8.50am and asked them if they wanted breakfast but did not offer them a drink; it was 9.04am before they returned with their breakfast and offered them a drink.

On the first floor we saw a member of kitchen staff bring the drinks and snack trolley around during the morning. The staff member offered people a choice of tea or coffee and asked if they wanted sugar adding. We saw a person who required thickener adding to their drinks, to reduce the risk of choking, was provided with their drink which had been thickened by the staff before the drink was served. People were offered a choice of biscuits or yoghurt.

We observed lunchtime on both the ground and first floor. There were tablecloths on the tables and condiments were in place. We saw staff prompted people to use hand wipes prior to lunch being served. On the ground floor we noted people were sat at the tables waiting for lunch. The main meal was shepherd's pie, we heard one person say they did not want this, and they asked for a jacket potato. Although staff accommodated this request the potato was served with butter and cheese, but staff had not asked the person what they wanted the potato serving with. Staff supported one person to eat their lunch; the person had their eyes closed when staff sat down to help them. We noted that staff did not tell the person what the lunch comprised of before they began to place the food in their mouth.

The tea time menu was listed as corned beef hash and chicken soup. We noted at tea time on the first floor no-one sat at the dining tables to eat, people either ate in their bedrooms or in easy chairs. People were provided with a sandwich and bun, which were presented to people at the same time and on the same plate.

Each of the care plans we looked at contained a care plan regarding the persons eating and drinking needs and a MUST assessment. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. Where weight loss was identified, people's records noted the action that had been taken. For example, informing the GP or referring to the dietician.

Staff recorded the dietary intake for some people who lived at the home. The records we reviewed were fully completed, recording how much of the food provided; the person had eaten, such as 'half' or 'all', but staff did not routinely record the size or amount of food offered. For example, staff simply recorded 'weetabix' or 'sandwiches'. This meant the records were not an accurate reflection of people's diet. We brought this to the attention of the registered manager.

We saw evidence in each of the care plans we reviewed that people received input from a variety of other health care professionals. This included GP's, district nurses, community mental health teams, dieticians and speech and language therapists. This showed people who lived at the home received additional support when required for meeting their care and treatment needs.

Roberttown Care Home has bedrooms over three floors with communal lounge and dining areas on both the ground and first floor. Bedroom doors were painted in a variety of colours and recorded the name of the

person whose room it was and the room number. This can help people to identify their own room. Doors on the corridors which were for staff use were painted white. This was so they blended into the décor of the home, reducing the risk of people trying to open doors. Store rooms were locked to reduce the risk of harm to people who lived at the home. Communal toilet doors were painted yellow and had a sign which included both words and a picture to indicate the purpose of the room. There was access to a garden from the ground floor lounge.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and kind. Comments included; "Anything I want, nothing is too much trouble", "Excellent, can't fault them", "Lovely girls" and "I like one of the male staff best, he's lovely and kind."

Staff told us people who lived at Roberttown were able to make choices about their daily activities. One of the staff said, "People get up when they want. [Name of person] makes their own choice, [person] says when they want to get up and go to bed." We saw examples throughout the day where staff encouraged people to make their own choices. We saw the registered manager and a member of staff transfer a person using the hoist, they asked them where they wanted to sit, the television was on and they asked them if they wanted it leaving on before they left them. We saw other staff assisted people to the lounge and dining area at lunchtime, staff consistently asked people where they wanted to sit.

Person centred care is where people's care is dependent upon each individual's needs, circumstances, likes, dislikes and preferences. We asked two of the staff we spoke with if they could tell us what person centred care was. One of the staff said they were not sure, although when they spoke with us they spoke about people as individuals and in a caring manner. The second staff we asked said, "Everything is around them, the individual. What they want and need to keep them happy and safe."

Throughout the inspection we observed staff interactions, the majority of which were caring and sensitive.

Each of the care plans we reviewed contained information about the person's life history, although the level of detail varied. For example, where a family member had completed the document, we saw more detail had been recorded. Information about people's life history can give staff valuable insight into people's needs, preferences, likes, dislikes and interests.

People who used the service had regular contact with their families, although the registered manager told us two people also had support from an advocate. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

People were supported to retain their independence. One of the staff we spoke with told us how they encouraged a person to walk short distances rather than use a wheelchair. They explained this was to ensure they retained a level of mobility. People were encouraged to maintain their independence at meal times, for example, staff cut up their food so they could still eat without assistance, and people used cups and beakers with lids and handles. Care plans were also written to promote peoples independence. One care plan recorded '[Person] can wash their own hands and face'. Maintaining life skills can promote well-being in people who need support with personal care tasks.

Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this. One of the staff we spoke with said, "We make sure they are clean, close doors when we do personal care. Speak to them like human beings, like you would anyone

else." During the inspection we heard staff taking to people discreetly. For example, we saw a person walk into the lounge; they said they wanted to use the toilet. A member of staff went to them, touched their hand and discreetly told them they would take them and show them where the toilet was.

Care plans referred to staff maintaining people's privacy and dignity whilst performing personal care and we saw care plans also recorded people's preference in regard to having their bedroom doors open or closed.

However, we noted an occupied bedroom on the ground floor had large windows which faced onto a public area. This meant the persons privacy and dignity may have been compromised. Staff told us the person spent time in their bedroom and due to memory problems; they were unable to make an informed choice regarding this aspect of their care. We also noted a bathroom on the first floor did not have a curtain or blind fitted. Although the window looked out onto fields and an adjacent flat roof, there was still a risk someone could be seen whilst accessing the bathroom. We spoke to the registered manager about these two issues and they assured us prompt action would be taken.

People's medicine administration records were stored electronically. We observed a staff member administering people's medicines and we saw them switch the computer screen to privacy mode when they left it to administer a person's medicine. This helped to ensure medicine records were not accessed by people who were not authorised to see them.

Not all records were stored securely. Care records were stored in the ground floor office. The office door was unlocked and accessible to anyone all day. The cupboard where the care plans were stored had a key in the lock but this was left unlocked. We asked a member of staff and they told us the office had to remain unlocked to enable staff to access the fire panel in the event of the fire alarm being activated. We discussed this with the registered manager and they assured us they would review the situation to ensure the fire panel was accessible and records were stored confidentially.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who lived at the home had entered the end stages of their life. A care plan named 'end of life wishes', dated 14 October 2016 recorded 'seen by the GP and has now entered the end stage of his life'. The care plan referred to practical elements of their care, for example, personal hygiene, but the care plan failed to capture the thoughts and preferences of either the person or their family in regard to how they wanted to be cared for at the end of their life. For example, their thoughts regarding the dying process, where they would like to be cared for in the final days of their life and who they may like to be consulted regarding their care in the event of a lack of capacity in the future. Advance Care planning is a key mean of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. We recommend the service seeks guidance from a reputable source, in regard to end of life care planning and record keeping.

Requires Improvement

Is the service responsive?

Our findings

People told us they enjoyed the activities provided at the home, although one person said they wanted more opportunity to go outside. A list of the planned weekly activities was on display on the notice boards within the home. This included a summer fete planned for the weekend and a visit from a therapy dog.

On the first day of our inspection we observed the activity co-ordinator asking two people which game they would like to play and then supporting them to play Connect Four. During the game they conversed about football. We also saw them provide a colouring book and pens for another person. They knelt on the floor beside them and placed a pen in the person's hands, and then supported their hand to prompt them to begin colouring.

In the afternoon an external company visited the home to provide a music and movement session for people. We noted that it took a number of minutes for staff to get people into the room, seated and ready to participate. This led to some people being unsettled and getting up from their chairs and walking around again. Once people were ready and the session began, people clearly enjoyed the activity, smiling, laughing and participating in the movement. However, we noted staff had failed to switch off the television, so at times people could hear both the television and the music from the activity session.

We reviewed the most recent activity records for seven people. The records noted the activities people were offered, if they had enjoyed the activity or if they had declined to take part. Engaging in regular activity and social interaction is a key factor in promoting well-being in older people.

Some of the care plans we reviewed were person centred and provided an adequate level of detail to enable people to receive safe and effective care. For example, the mobility care plan for one person incorporated the advice of an external healthcare professional. We observed the support two people received from staff while they were in the lounge and we saw their care plans reflected the care we had observed.

However, a person who had recently been admitted to the home had no care plan in place for moving and handling, pressure area care although their daily records noted they required the use of a hoist and were being repositioned two hourly. The care plans for another person were not all reflective of their current needs. Their sleep and waking care plan dated 16 October 2016 recorded 'will inform staff when they wish to hoist them into bed', staff had written underneath this entry '[person] now spends the day in bed – given the choice' however, we were told by staff they were currently being nursed in bed due their current poor health.

Where people exhibited behaviour which may challenge others, the care plans lacked detail to enable staff to manage these situations efficiently and effectively. We observed one person becoming increasingly anxious on two separate occasions, but their care plan made no reference to them exhibiting this behaviour or what techniques staff may deploy to defuse the situation or reassure the person.

When people had a bath or shower, this was recorded on a form but the form did not enable us to see if the

person had a bath or a shower and therefore we could not be assured the care they had received was in line with their personal preferences. We raised this with the registered manager and when we returned for the second day of the inspection we saw they had amended the form to make this information clearer. We looked at a random selection of reposition charts for one person. The section where staff were to record the frequency of their pressure relief was all blank. When we reviewed the night check records for one person, we saw the times were pre-recorded on the document, for example; 20.30, 21.30. This meant the records may not be an accurate reflection of the time people were checked by staff.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew who to complain to in the event they were dissatisfied with the service. One person said, "If I'm not happy, I can speak up." Another person said, "I would complain to a senior."

Complaints were recorded and we saw copies of the written responses sent to the complainants which, where appropriate, contained an apology. We also saw the complaints policy was on display in the reception area of the home. This showed people there was a system in place to manage complaints.

Requires Improvement

Is the service well-led?

Our findings

During our conversations with staff they did not raise any concerns regarding the management and leadership of the home, each of the staff we spoke with said they enjoyed working at Roberttown. Staff told us that despite the registered manager's office being in a separate building, adjacent to the home, they were regularly present in the home. Staff were also confident they could raise any concerns. One staff member said, "Any poor practice, I would speak to the staff involved and tell either [name of registered manager] or [name of deputy manager]." Another staff member said, "It is a homely home."

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met. The registered manager told us they had been employed at the home for nearly two years. They said they wanted people to feel that Roberttown was their home, for people to live in a family environment and be seen as a person and not as a condition.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection was on display within the home and the rating, along with a link to the CQC report was also available on the registered provider's website.

We saw the registered provider had a range of policies; these were dated and included a timeframe for review. Reviewing policies helps to ensure they are up to date and reflective of current legislation and good practice.

The registered manager told us a range of audits were competed by themselves and other staff members. We saw audits of people's weights, pressure sores, care plans, bed rails and mattresses, hoist slings, catering and the dining experience. We reviewed a random sample of completed care plan audits; the auditor had recorded where issues were identified and when they had been rectified.

The registered manager told us they compiled a monthly report which was submitted to the senior management team. We reviewed the report dated May 2017 and saw it included a variety of statistics including accidents, complaints, staff training and supervision and notifications submitted to the Care Quality Commission. The registered manager said the management team held a governance meeting the week after the submission of the report for them to review and analyse the findings and take action where a need was identified.

The registered manager told us a senior manager visited the home on a monthly basis and completed a

compliance report, the findings of which were shared with the registered manager. We saw a compliance report had been completed in January, April and June 2017. We noted the 20 June 2017 report recorded the registered provider's new documentation for MCA and DoLS was yet to be implemented. This was listed as an action to be addressed by the registered manager, although no timeframe for completion was recorded. Following the inspection the registered manager submitted a report which they told us was from a Compliance report in April 2017, this recorded the new documentation was to be put in place over the following three months, however, this information was clearly not carried to future Compliance reports.

Staff told us meetings were held on a regular basis. The registered manager told us general staff meetings were held at three separate times during the day to enable staff to attend. We saw minutes from recent meetings were displayed on the notice board in the staff office and we saw minutes from a variety of other meetings were retained in the registered manager's office. Where action points were recorded in the minutes, the outcome or follow up to these points was not always recorded. This helps to evidence actions have been completed and if they were effective.

We saw evidence feedback was gained from people who lived at the home and their relatives. The registered manager said meetings with people who lived at the home and their relatives were held quarterly throughout the year, although they said attendance at the meetings had reduced. We saw minutes dated March, May and August 2017, items discussed included building work at the home, feedback from a local authority monitoring visit and staffing. The registered manager told us quality surveys were distributed to people, relatives, staff and relevant health care professionals twice a year. We saw 'you said, we did' on display in the reception area. This gave feedback to people from the most recent quality survey completed in December 2016.

This evidence demonstrated the registered provider had a system in place to assess and monitor the performance of Roberttown Care Home. However, this system was not robust enough to identify and drive improvements. As evidenced within this report, we found concerns in relation assessment of risk, people were left unsupervised, the requirements of the MCA were not fully met, people's records were not stored confidentiality, and people's records were not always an accurate reflection of their current needs. These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all aspects of people's care had been robustly assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not sufficiently robust. Records were not secure and were not always an accurate reflection of people's current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably deployed staff to ensure peoples safety and needs were maintained.