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The Royal Elms Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 28 and 29 October 2015 and was unannounced. At the last inspection, in April 2014, the service was judged compliant with the regulations inspected.

The Royal Elms is a care home offering accommodation and care for up to 26 older people. The home is situated in the Newton Heath area of Manchester. Bedrooms are situated on both the ground and first floor of the home. There are gardens to the rear of the home and limited parking at the front of the building.

The service has a registered manager who has been registered with the Care Quality Commission since March 2013. 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 arrangements for handling and administrating medicines required some improvements to ensure it was safe and people received their medicines as prescribed. We found the drugs store room needed some attention to ensure it was suitable for the storing of medication. There

Summary of findings

was no suitable arrangement for hand washing to prevent cross infection. Protocols to manage 'as required' medications (PRN) were not sufficiently detailed. You can see what action we told the provider to take at the back of the full version of the report.

Procedures in relation to recruitment and retention of staff were robust and ensured only suitable people were employed in the service. We found staff were mostly skilled and experienced staff and there was a programme of training. However some staff had not received up to date dementia awareness training. Supervisions were taking place regularly however; staff had not received their appraisal which gives staff an opportunity to discuss their development. You can see what action we told the provider to take at the back of the full version of the report.

Staffing levels were adequate although from our observations we found staff were only able to meet the basic needs of people. We saw very little interaction with people and conversations were mainly in relation to the care tasks that staff were undertaking. Sufficient domestic hours should be deployed to help control and reduce the risk of infection.

The manager was aware of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place and key staff had been trained. This helped to make sure people were safeguarded from excessive or unnecessary restrictions being place on them.

The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. We found the registered manager was following the guidance and had made one referral to the supervisory body to restrict one person's liberty. This was applied for to prevent the person from harm.

We were only able to speak with two people who used the service. This was because most of the people living at the home were unable to communicate with us in a meaningful way as they had limited mental capacity. Therefore we carried out observations throughout the inspection. We also spoke to visitors to the home during the inspection to gain their views of the service.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made. We saw evidence that the home worked closely with GP's, district nurses, community psychiatric nurses, dieticians and tissue viability nurses. However we found one care plan had not been followed to obtain a urine sample for a person when the GP had requested it. The registered manager and deputy manager were unaware that the sample had not been obtained.

We found staff approached people in a kind and caring way and we saw people were respected and treated in a dignified manner. However, staff spent most of their time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service.

Staff told us they felt supported and they could raise any concerns with the manager and felt that they were listened to. Relatives told us they were happy to raise any concerns directly with the registered manager.

We found the systems in place to monitor and improve the quality of the service were ineffective. The registered provider told us that they visited the home once or twice a month and spoke to the registered manager on a regular basis but they did not produce a report which could demonstrate how progress was made with any actions required. The registered manager told us that she regularly checked care plans to ensure they were up-to-date but did not record any actions. Some care plans we looked at were not up-to date so the monitoring system was not effective. The registered manager told us that people were consulted about their views at regular intervals. You can see what action we told the provider to take at the back of the full version of the report.

The service user guide told us that the home specialised in dementia care. However, the environment was not dementia friendly in the use of colours furnishings and carpets. Signage was poor which meant people would find it difficult to orientate themselves around the home.

Summary of findings

Parts of the environment were not fit for purpose and could cause injury to people who used the service. You can see what action we told the provider to take at the back of the full version of the report.

We saw no evidence of personalised features by the entrance to bedrooms to help people find their own rooms. Bedrooms had numbers on the door that were difficult to read in the light available and had no personalised distinguishing features that would be routinely found in a dementia care home that has been thoughtfully organised to meet the needs of people living with dementia. There were no handrails on the corridors on the first floor which made it difficult for people to move around independently.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

Medicines were administered safely. However, we found some of the systems to record medication were not sufficiently robust. This meant there was potential to make errors when administering medication. The medication store room needed some improvements to prevent the risk of cross infection.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard people from abuse.

Staffing levels were adequate although the number of staff working during the night may not be sufficient to ensure the safety and welfare of people who used the service. This is because staff were expected to undertake domestic duties which may distract them from meeting people's needs. Sufficient domestic hours should be deployed to help control and reduce the risk of infection.

We found staff approached people in a kind and caring way and we saw people were respected and treated in a dignified manner. However, Staff spent a lot of time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service.

There were robust recruitment systems in place to ensure the right staff were employed.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received regular supervisions, however yearly appraisals did not take place. This meant staff were not given the opportunity to discuss how they were performing in their job role.

Each member of staff had a programme of training and were trained to care and support people who used the service safely.

The design of the premises was not dementia friendly, some furnishings such as carpets and bathing facilities needed replacement.

The staff understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. The registered manager demonstrated a good awareness of their role in protecting people's rights.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people living in the home. We observed people being given choices of what to eat and what time to eat.

Summary of findings

Is the service caring?

Good

The service was caring.

We saw staff had a warm rapport with the people they cared for. Staff attended to people's personal care needs in a respectful way and maintained their dignity throughout. Relatives spoke positively about the staff at all levels and were happy with the care.

Relatives told us they felt involved in their family members care and had been invited to attend reviews of their family members care.

Is the service responsive?

Requires improvement

The service was not responsive.

We found that people's needs were assessed prior to them living at the service. However, it was not always possible to obtain a full picture of people's care needs and risks or track progress as some care records were not up to date. Activities were infrequent and we observed times when staff were not available to offer support to people.

Communication with relatives was good. One family member we spoke with told us that staff always notified them about any changes to their relatives care.

The service had a complaints procedure that was accessible to people who used the service and their relatives. Relatives told us they would go to the manager if they had any concerns

Is the service well-led?

Requires improvement

The service it was not well led.

There was a registered manager in place.

The systems that were in place for monitoring quality were ineffective. The registered manager was unable to demonstrate how actions were taken to improve the service.

Relatives were regularly asked for their views. The manager told us that she operated an open door policy which invited relatives to raise any concerns

Accidents and incidents were monitored monthly by the registered manager to ensure any triggers or trends were identified.

The Royal Elms Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 28 and 29 October 2015 and was unannounced. The inspection team consisted of an adult social care inspector and an expert by experience with expertise in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 22 people using the service. We were only able to speak with two people who used the service. This was because most of the people living at the home were unable to communicate with us in a meaningful way as they had limited mental capacity. We spoke with the registered manager, the deputy manager; we spoke with the provider on the second day of the inspection. We also spoke with four care staff and the cook. We spoke with two visiting relatives. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spent time observing care throughout the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We did not ask the provider to send us 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.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also spoke with the local council quality assurance officer who also undertakes periodic visits to the home. They told us they had no concerns about how the service was run.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at four people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires improvement

Is the service safe?

Our findings

We spent time observing how staff related to people who used the service. All of the people using the service were living with a diagnosis of dementia and many had a high level of physical care needs and poor mobility. This meant that staff spent a lot of time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service.

There was a policy in place for the ordering, storage and administration of medicines. The stock room was appropriately secured and only accessible to authorised staff. However, we saw the room did not have a sink to enable the senior to wash their hands after administering medications. The nearest sink was across the lounge and down a corridor. A small tub of water was used to wash used medicine pots and they were left to dry on a table in the room. However, above the table we saw there was a large gap in the ceiling where debris and dust could fall and contaminate items and medication in the room. The deputy manager told us the damaged ceiling occurred some weeks ago. We also noted that a waste bin in the room did not have a top on which exposed used materials.

The deputy manager told us they did not hold any controlled drugs but pointed out that they had the facilities and records if required. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were managed safely in line with current legislation.

We found a lack of information to guide staff how to safely administer 'when required' medicines.

We were shown protocols that were used for administering pain relief medication but it lacked detail which guided the staff to understand how the person presented when in pain. This could be confusing leading to more medicine being administered than the person required.

We were told that staff administering medicines regularly had their competence checked and this was confirmed by the registered manager. We saw evidence to support this.

The above was a breach of Regulation 12 (2) (f) (g) (h) safe care and treatment; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about their understanding of protecting adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They said they would report anything straight away to the registered manager. We saw staff had received training in this subject.

The manager told us that they had policies and procedures to manage risks. Staff understood the importance of balancing safety while supporting people to make choices, so that they had control of their lives. There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. We saw there was an up to date fire risk assessment which had been agreed with the fire safety officer.

We carried out two SOFI observations during the inspection of the service. We spent 20 minutes in the large lounge where most people were sitting. During this time no staff were present. This meant people at risk of falling were not monitored to prevent accidents occurring. We spoke with the deputy manager about this and she told us that she was still administering medication and the other two staff were still attending to people's needs that were in bed. During this time we observed that people were sleeping or looking disinterested in their surroundings. A chat show was playing on the television but people were not engaging with the programme.

We reviewed accidents, incidents and safeguarding concerns in the service since our last inspection. We saw that accidents were reviewed however it was not clear what actions were taken to prevent reoccurrences. We found that no safeguarding referrals had been received from the home. The registered manager confirmed that there were no safeguarding's currently being investigated by the local council.

We found that the recruitment of staff was robust and thorough. This ensured only suitable people with the right skills were employed by the service. The manager told us how they would recruit new staff if required. We checked six staff files and found appropriate checks had been undertaken before staff began working for the service. We saw a reference to confirm that a satisfactory Disclosure and Barring Service (DBS) check had been undertaken. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires improvement

Is the service safe?

Through our observations and discussions with relatives and staff members, we found there were only sufficient staff to meet the basic needs of the people living in the home. We observed that staff spent most of their time meeting personal care. People living with dementia were not given the stimulation and support expected of a service which specialises in dementia care. Within staffs roles and responsibilities staff were expected to undertake some domestic duties. We noted that the domestic worked five hours on five days of the week. A care worker covered when the domestic was off. The manager told us that the staff working on domestic had recently reduced their hours following a period of sickness. This meant on some occasions bedrooms were not thoroughly cleaned each day.

The laundry was situated in the basement of the home which meant when care staff were in the basement they were not able to observe if people required attention. The two waking night staff were also expected to clean communal areas during the night. Staff working at the home told us that a number of people were up during the night and would require supervision to keep them safe. We were also told that a number of people also required two staff to turn and attend to personal care needs. This meant that both staff would be occupied at different parts of the night, which meant others may not be closely supervised. We spoke with the registered manager and the provider about our concerns, although they felt the numbers were sufficient to meet the needs of people who used the service.

The care we saw was kind and compassionate although with the number of staff on duty interactions with people were limited to undertaking personal care.

We looked around the home to assess if cleaning and infection prevention and control was effective. We saw some areas had been damaged when there was a problem with the roof. The provider told us that this had been resolved and corridors upstairs had been re-plastered, but had not been decorated. A shower room upstairs was not used as debris was still in the room from the leaking ceiling. This meant only one bathing facility was in use situated on the ground floor. This meant choice was limited for people who required a bath. The bathroom on the ground floor was in poor repair and could cause injury to a person as the side of the bath was damaged leaving sharp edges. We have asked the provider to send us a refurbishment programme with details of how they intend to improve the environment. Carpets on the corridors were in need of replacement and difficult to clean to a good standard. Parts of the carpets were shaded which made it difficult for people living with dementia to move around safely.

The above was a breach of Regulation 12 (2) (d) - (h) safe care and treatment; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that care staff wore personal protective equipment (PPE) when delivering personal care and practised good hand hygiene. One relative we spoke with told us, “Sometimes there is a little odour but the staff act quickly to resolve the problem, the standards are okay I think.”

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights. The Deprivation of Liberty Safeguards are aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

We checked whether people had given appropriate consent to their care and where people did not have capacity to consent, whether the requirements set out in the Mental Capacity Act 2005 had been adhered to. The registered manager told us that most staff had undertaken training in this subject. She told us that she had made one urgent and standard application to the supervisory body which deals with all applications of this nature. This application was still awaiting authorisation. She told us that she was aware that she needed to consider if DoLS were needed for other people.

We looked one person's file and found that they had a mental capacity assessment which concluded that they were resistant to receiving care, and did not have the capacity to consent to receiving care. Their file contained no evidence that any decisions relating to their care had been made in their best interests, in accordance with the Mental Capacity Act. The manager told us that the person's needs had changed although the care plan did not reflect this.

A second person's file showed that they lacked capacity. However we were unable to see how staff had considered and recorded their consent to care and treatment. We discussed this with the registered manager and she told us that new documents were being introduced to demonstrate how decisions were made when people had limited mental capacity. On the second day of this inspection some of the missing documents were awaiting discussion with family members.

Another person's file contained information stating that they had a diagnosis of dementia and had been assessed as lacking mental capacity and had tried to leave the building. This meant they may be at risk of harm or that they may not be able to find their way back to the home. There was no evidence that a best interest meeting had taken place or a DoLS application applied for to restrict them from leaving the home. We discussed this with the registered manager and deputy manager who told us that the persons care needs had changed and they no longer attempted to leave the building.

We noted that CCTV was in use in the dining area and corridors; however there were no signs displayed in the home to inform people that surveillance systems were in use in the home. The registered manager told us the CCTV was fitted to reduce the risk of falls. However, CCTV was also fitted in the kitchen area, which no people who used the service could access. There was no evidence available to confirm how the provider had consulted with the people who used their service, families, and other regular visitors when deciding about whether and how to use surveillance.

We were told that one person's bedroom was used regularly as place where the hairdresser attended to people's hair. We discussed how consent was gained from the person to ensure they did not feel this was an intrusion of their privacy. The registered provider told us that the person had limited mental capacity and would not be able to give the consent but they had asked permission of the daughter who had given verbal consent.

The above was a breach of Regulation 11(1) – (4) need for consent; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had suitable arrangements in place that ensured people received good nutrition and hydration. We looked at five people's care plans and found that they contained detailed information on their dietary needs and the level of support they needed to ensure that they received a balanced diet. Where people were identified as at risk of malnutrition, referrals had been made to the dietician for specialist advice. The service had been part of the 'Tamsin' Programme. TAMSIN(Training and Mentorship Support in Nutrition Programme) provides mentorship to staff to increase nutritional awareness; carry out individual assessments of people who use the service; review and improve the mealtime experience; and conduct menu analysis. The support helped to reduces reliance on nutritional supplements and reduced avoidable hospital admissions.

We joined a group of people eating their meals. We observed lunch and tea taking place on the first day of the

Requires improvement

Is the service effective?

inspection. The menu board displayed hand written details of the meals available, however this was difficult to read and no effort had been made to make it suitable for people living with dementia.

People that needed support to eat their meals were provided with care that was supportive of their needs and was carried out in a professional and sensitive manner. Meal times were unrushed and all of the people involved appeared to enjoy their meals. One person told us, "The cook makes very good dinners – I really like the bacon ribs and cabbage." Another person said, "I get a full English breakfast which I would never have at my home. I'm really going to miss that when I go home. I think I'm in a posh restaurant here."

The cook told us they received training specific to their role including food safety, healthy eating and food processing. They had a good knowledge of specialist diets. The cook had knowledge about the latest guidance from the Food Standards Agency. This was in relation to the 14 allergens. The Food Information Regulations, which came into force in December 2014, introduces a requirement that food businesses must provide information about the allergenic ingredients used in any food they provide.

Records we looked at confirmed staff were trained and received updates. Managers and care staff had obtained nationally recognised care certificates. The registered manager told us all staff would complete a comprehensive induction which included, care principles, service specific training such as, equality and diversity, expectations of the service and how to deal with accidents and emergencies. Staff were expected to work alongside more experienced staff until they were deemed to be competent.

The manager was aware that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015.

The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Systems to support and develop staff were in place through regular supervision meetings with the registered manager. However, yearly appraisals did not take place. This meant staff were not given the opportunity to discuss further training and development or how they were performing in their job role.

Staff confirmed to us that they received regular supervision on an individual and group basis, which they felt supported them in their roles. Staff told us the registered manager was always approachable if they required some advice or needed to discuss something.

Given that the care home's 'Service user guide' promoted the Royal Elms as a care home suitable for people with dementia, there was little evidence of facilities and activities designed to support the needs and best interests of people living with dementia. The general floor covering/ carpeting, decoration and lighting in the home showed very little regard for the needs of people living with dementia.

The environment had not been organised to help people living with dementia find their way around the care home in terms of colour or lighting schemes. There was minimal signage to help people negotiate their way around the dimly lit corridors in a safe manner. In the corridors shadows were cast by the poor lighting that made it very difficult to see the undulations in the surface of the floor. The dining area in particular had a slight slope which was not visible when people approached it. This could lead to accidents if staff were not in attendance. We saw one recent accident report that occurred in this area of the dining room.

Good

Is the service caring?

Our findings

We saw that staff knew people who used the service very well and there was a relaxed atmosphere throughout the building. One person we spoke with said, “The staff are very polite and respect my privacy. They help me when I need it. They are all very nice.” Another person said

“I am happy here and most people seem to be happy because we get proper attention.” “We are very well looked after here. I am very comfortable here. I do not want to return to my home.” A relative we spoke with told us that their family member always appeared happy with the care. They said, “The staff are friendly and I have confidence in them to look after my relative.”

The best interaction we observed was during lunch when staff sat with people to give assistance with their meals. Staff actively engaged with people and gave encouragement when needed. Other interactions with people were very task led. Staff did not engage with people in a meaningful way when they passed people it was generally “Are you okay,” “It will soon be lunch time and do you need the toilet.” Were typical of the conversations we heard.

We saw some files we looked at contained a ‘My life story’ and ‘My life now and onwards’ documents however they were not always fully completed. These are tools for relatives of people living with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes. The information helped staff to better understand a person’s needs if they could not fully respond to the questions staff asked when getting to know them.

We spoke with the registered manager about dementia champions. She told us that all staff were dementia champions; however it was difficult to establish how the home demonstrated this in the day to day activities in the home. Staff had not received training to be a dementia champion and we could not evidence that they used a dementia model to promote good care for people living with dementia.

There were three recent ‘thank you’ cards from relatives following the death of a loved one who had passed away in the care home. They all expressed gratitude about the way their relative had been cared for at The Royal Elms. One staff member told us that people were informed about the death of another person. One staff member who we spoke with said they had arranged for some people to attend the funeral with the family’s permission. They said if the funeral proceedings are local to the care home staff asks if the funeral cortege would drive past the care home so that people could show their respects if they wanted to.

Relatives and visitors to the home told us that there were no restrictions to the times when they visited the home. One relative said, “I come every day at different times and there has never been a problem. Staff always greets me in a friendly manner and offers me refreshments.” Another relative said, “I have been on occasions when staff have not been present in the lounge and I get worried residents may fall but staff then appear having been dealing with a resident.”

Requires improvement

Is the service responsive?

Our findings

We spoke with people about how they were able to access activities. People told us they had particularly enjoyed the recent trip to Blackpool to see the lights and they had a fish and chip supper. Although they were disappointed that they could not get off the bus to stretch their legs and get some fresh air. During the first day of our inspection we did not observe any activities and raised this with the registered manager. She told us that there was no dedicated activity staff member and they relied on certain staff to provide activities. On the second day of this inspection we observed a sing-song although this was not the activity that was on the displayed activity planner.

A monthly activity schedule was pinned to the notice board by the dining room. Unfortunately the notice board was at a height that most people could not see and the information was printed in a very small font size that was difficult to read. The monthly activities schedule reflected the limited resources allocated to improving the quality of life for people who used the service.

There was no engagement with volunteer groups to provide art and craft opportunities or to organise visitors who could read to people and keep them in touch with what was happening in their community. The registered manager told us that an outside entertainer attended once each month and two people had the opportunity to go to a local pub for lunch. Although this had not taken place recently. Staffing levels were such that only two people could attend the pub each time because they required assistance from staff.

We found that people's care and treatment was regularly reviewed although this was not always effective as some of the evaluations did not reflect the up to date care needs of the person. For example we saw a doctor had asked for a urine sample to be obtained following a visit to the person on the 22/10/2015. However, there was no further entry to confirm the sample had been obtained and if any further treatment was required. We noted this on 29/10/2015. We spoke with the deputy manager about this and she said she was unaware that a urine sample was required. Relatives we spoke with told us they were able to discuss any concerns with the registered manager.

We also noted that on one person's review it referred to the person as being at risk if they left the building. However when we asked the registered manager and deputy manager about this they both confirmed that the person no longer attempted to leave the building.

The above was a breach of Regulation 9 (3)(a)(b)(c) person centred care; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that copies of the home's complaints policy were displayed throughout the home. People and their relatives we spoke with mostly said they had no complaints but would speak to staff if they had any concerns. The registered manager told us that there had not been any formal complaints within the past year. Our review of the provider's complaints folder confirmed this.

The registered manager told us that she operated an open door policy to encourage people and their relatives to discuss any concerns they may have. She told us she had held a residents' meeting to discuss the trip to Blackpool and holding a Halloween party. We saw minutes of the meeting held.

Staff told us if they received any concerns about the services they would share the information with the registered manager. They told us they had regular contact with their manager both formally at staff meeting and informally when the registered manager carried out observations of practice at the home.

Requires improvement

Is the service well-led?

Our findings

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

Relatives we spoke with told us they thought the service was well led. One relative said, “The manager and her staff always makes sure they inform us about any changes to [my relatives] care.

Care staff had received regular supervision however they had not received a yearly appraisal. This meant staff were not given the opportunity to discuss how they were performing in their job role. The registered manager told us she had not considered this as part of her monitoring of the service.

Quality monitoring systems were ineffective. There was no evidence of remedial action being undertaken when issues had been identified. We looked at a number of audits, for example, the medication audit. The registered manager told us that they checked care plans to ensure that they were up-to-date although she said she did not formally document her findings. She was aware that some care plans required updating but did not have details. The registered provider told us that they visited the home once or twice a month and spoke to the manager on a regular basis but they did not produce a report which could demonstrate how progress was made with any actions required. We were told that there were no audits to ensure the service managed risk effectively. The provider told us that they were unable to show us any refurbishment plans. Without a scheduled plan of refurbishment we were unable to determine when improvements to the environment would be completed.

We found the registered manager had a good understanding of her legal obligations to ensure the principles of the Mental Capacity Act were being met. However we found care plan documentation did not always reflect how consent to care and treatment had been gained.

We looked at the statement of purpose for The Royal Elms Care home which stated that they specialised in dementia care. We found the environment did not promote good dementia care. The registered manager could not demonstrate a good insight into the models and principles used to promote dementia care.

Staffing levels were such that staff were only able to meet the basic personal needs of people who used the service. We have asked the registered manager to review the levels provided at the home.

This was a breach of Regulation 17 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 legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Regulation 9 (3)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People did not receive care or treatment in accordance with their wishes. People were not always asked for their consent about the observations arrangements in the home. Regulation 11 (1) - (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to record and store medicines. Infection prevention and control measures were not always robust Regulation 12 (2) (d) - (h)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems to regularly assess and monitor the quality of service that people receive. The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regulation 17(1)(a)(b), (2)(b)(iv)(c)(I)