Roberttown Care Home Limited

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Inspection report

98 Church Road
Roberttown
Liversedge
West Yorkshire
WF15 8BE

Tel: 01924411600

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 25 October and 2 November 2018 and was unannounced. We previously inspected the service on 29 June and 4 July 2017 and we rated the service requires improvement. This was because the service was not meeting regulations relating to safe care and treatment, good governance and staffing. Following the last inspection we asked the registered provider to complete an action plan to show what they would do, and by when to improve the key questions of whether the service was safe, effective, caring, responsive, and well-led.

During this inspection we identified the home had made some improvements. People had appropriate risk assessments for how they were supported to move. Staffing levels were appropriate to support people's needs and were reviewed regularly. However, the service remained in breach of regulations relating to safe care and treatment, good governance and staffing. We found the service had failed to identify inaccuracies in certain aspects of the home's management and staff did not receive regular supervisions and appraisals. This is the third time the service has been rated as requires improvement overall. You can see what action we told the provider to take at the back of this report.

Roberttown Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Roberttown Care Home provide care and support to older people, some of whom are living with dementia. The home has a maximum occupancy of 29 people. On day one of our inspection there were 25 people living at the home and on day two of our inspection there were 26.

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.

People told us they felt safe and staff were aware of the importance of reporting concerns to senior staff. The records kept by the service did not always evidence how the registered manager responded to these concerns.

Care plans contained individualised risk assessments, however not all had adequate information to ensure people's care and support was safe. Personal emergency evacuation plans (PEEPs) did not contain up to date information.

Premises were maintained safely and appropriate checks completed.

Systems were in place to reduce the risk of employing staff who may not be suitable to work with vulnerable people, however in some instances gaps in people's employment history had not been checked.

An electronic medicines administration record (EMAR) was in place to monitor and manage the administration of medicines. This was used safely however the administration of topical creams were not always recorded consistently.

New staff received an induction to the home which included mandatory training and shadowing more experienced colleagues. Staff received ongoing training, however they did not have access to regular supervisions and appraisals.

Mental capacity assessments were decision specific and people were deprived of their liberty lawfully. Staff awareness of mental capacity was good.

People were offered a good choice of meals. Their nutritional risks were assessed and weight loss monitored and appropriate action taken when necessary.

People had appropriate and timely access to external healthcare professionals.

People told us staff were caring and kind. Staff were knowledgeable about people and encouraged people to make choices about their daily lives and retain a level of independence. Staff were aware of the need to maintain people's privacy, dignity and confidentiality, however we observed on two occasions people's records were not always locked away.

People's care plans were person-centred and detailed and although regular reviews of people's care took place people's care plans were not always updated to reflect their current care and support needs. The actions the service took to meet these needs was not always recorded in people's daily records.

There was a good range of activities and people received one-to-one activity time on a daily basis.

People were aware of how to complain. Although the registered manager responded to verbal concerns they did not record these.

People were asked about how they would like to be cared for at the end of their life and their wishes were recorded.

Staff had mixed opinions about how well the registered manager managed the home. Minutes of staff meetings did not record any feedback given by staff about the service or show their involvement had been sought in making improvements.

A range of audits were completed on a regular basis to assess the quality and safety of the service, however some audits were not effective. They had failed to identify the issues we found during this inspection. Where responsibility for audits had been delegated, staff had not received appropriate training to complete these

audits effectively.

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 audited the quality of the service people received. However, some of these systems of governance had failed to identify the issues we have evidenced within our 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.

Staff knew how to protect people from abuse however safeguarding concerns were not always recorded.

Medicines were administered safely however the administration of topical creams were not always consistently recorded.

Staff were knowledgeable about how to use equipment appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive regular supervision and appraisal.

People's nutrition was monitored and they had a good choice of food and drink.

People were appropriately supported to access external healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff treated people were treated with kindness, dignity and respect.

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

People's communication needs were recorded and the home supported alternative methods of communication.

Is the service responsive?

Good

The service was responsive.

There was a wide range of person-specific and group activities provided at the home.

People's care plans were person-centred and detailed but were not always up-to-date.

Complaints were responded to within appropriate provider timeframes.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

There was a system of regular auditing but this had been ineffective in identifying discrepancies in record keeping.

Staff views about how the service could be improved were not obtained.

Regular feedback was sought from people and their relatives.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 October and 2 November 2018 and was unannounced. This meant the service did not know we were visiting. The inspection team comprised two adult social care inspectors on both days of the inspection.

Before our inspection visit we reviewed the service's inspection history, current registration status and notifications we received from the registered provider. Providers are required by law to notify us of certain events, such as when a person who uses the service suffers a serious injury. We contacted commissioners of the service, the local safeguarding authority and Healthwatch to find out whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with five people who lived at the home and three of their relatives or friends. We spoke with the registered manager, the regional support manager, two senior care assistants, five care assistants, the activities co-ordinator, a cook and a kitchen assistant. We looked around the building and

saw the communal lounges, dining rooms and bathrooms. People showed us their bedrooms. We spent time observing care in the communal lounges and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records, which included five people's care files. We also looked at five staff members' recruitment and supervision documents, staff training records and other records relating to the management and governance of the home.

Requires Improvement

Our findings

People living at the service and their relatives told us they felt safe. Comments from relatives included, "There are always staff around during the day", "They look after [person's name] well" and "I'm very happy with the care here."

A staff member said, "Safe? Yes, [people] are well looked after."

Staff had completed safeguarding adults training and were aware of their responsibilities in protecting people from abuse. A staff member described one of the ways to notice if people were being abused by saying "if residents go quiet". Another staff member said, "If I was concerned…I would use the whistleblowing procedure. I'd sit with [people] and let them tell me what happened. I would tell the senior or the manager and make sure they did something about it. If they didn't, there's a book in the office that tells me who else I can contact."

Concerns were not always recorded or referred to the relevant authority. The registered manager described how they had received concerns from staff, which may have involved people being unsafe in the home. Although the registered manager had responded appropriately to address the concerns, they had not identified the importance of recording this or considered notifying the local safeguarding authority and the Care Quality Commission (CQC). Registered persons have a legal responsibility to notify the CQC of certain incidents such as any allegations of or incidents of abuse.

On day one of our inspection the registered manager was absent and a senior care assistant was in charge because the deputy manager was off work due to long-term sickness. The senior care assistant had not been provided with all the information required for them to manage the home in the absence of the registered manager. We spoke with the registered manager and the registered provider about this. They told us they were going to review the home's business continuity plan and contingency arrangements to ensure detailed information was available to staff left in charge of the home.

Systems were in place to evacuate people safely in the event of an emergency however these systems were not kept under review to ensure they would be effective. The fire evacuation plan included a zone by zone breakdown of what action staff should take unique to each zone. A person who had moved to the home recently had not been included in the list of people in the 'emergency grab bag'. This meant the home had not taken appropriate steps to ensure this person would be safely evacuated in an emergency.

People's personal evacuation plans (PEEPs) were not always up to date nor did they contain accurate information to support their safe evacuation. For example, a PEEP for one person recorded they were 'slow/steady with a frame' but the grab sheet information said they would need a wheelchair. We discussed this with the registered manager who assured us these would be updated by the end of the week.

Risk assessments were individualised. For example, there was a detailed risk assessment surrounding the use of oxygen for one person. Risk assessments supported the promotion of people's independence however they were not always up to date. For example, one person had recently suffered a fall and there was inconsistent recording of the information about this. A body map showing the injuries the person suffered was not in the person's care plan but was in the registered manager's accident and incident analysis. This meant staff reading the care plan would not know where the person was injured. The person's daily records showed a GP had visited but this had not been recorded on the 'records of doctor's visits'.

Recruitment was not always undertaken safely. Staff files showed gaps in three people's employment histories had not been checked and interview notes were not retained for these staff members. In another staff member's recruitment record we saw a reference had been received the day after the staff member had started work. This meant the home had not fully assured people were protected from the risk of unsuitable staff. However, we saw checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Medicines were administered by senior staff using an electronic medicines administration record (EMAR). EMARs were up-to-date and provided an accurate record of people's medicines, which corresponded to medicines held in stock. Records showed senior staff received annual training however their competency to administer medicines was not reviewed regularly. This meant the service had not ensured all staff were competent to administer medicines safely.

The EMAR system automatically provided a daily alert to the registered manager confirming whether there have been any discrepancies in the administration of medicines. The registered manager checked these on a daily basis. Of the sample we looked at there had not been any medication errors.

Protocols were in place for medicines prescribed on an 'as and when required' (PRN) basis and these were kept on the EMAR as well as in people's care plans. These provided guidance to staff about the circumstances under which the PRN medicines could be administered. In one instance the person's care plan did not record they had any PRN medicines prescribed. We brought this to the attention of the registered manager who arranged for a review of everyone's care plans to ensure these were consistent with the details held in the EMAR system.

A paper-based topical medication administration record (TMAR) was used to manage the application of prescribed topical creams and was used consistently. This meant these were administered safely however there was some inconsistency in where this information was recorded. For example, one person's daily log showed the administration of topical creams recorded but this was not always recorded in other people's daily log. We discussed this with the registered manager who arranged for the process to be reviewed to ensure consistent recording.

Evidence demonstrates we found concerns in relation to how concerns about people's safety were recorded, a lack of information about how the home would be managed in the absence of the registered manager, inaccurate recording of people's emergency evacuation needs, staff recruitment, inaccurate recording of people's emergency evacuation needs, staff competency to administer medicines, and

inconsistent recording of people's PRN and topical cream applications. These findings demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager reviewed people's needs on a weekly basis and completed a dependency tool to assess staffing levels. Staffing rotas were produced in advance each week. During the inspection we found there were sufficient numbers of staff to meet people's needs. Staff were not rushed and the atmosphere was calm. A staff member told us, "There's enough time to care…We've got enough staff to make sure people are cared for safely." However, another staff member said, "We've no staff. We've had people start and they don't last long," and staff told us there were difficulties when people were off work sick, which they said happened frequently, and during the recent summer annual leave period. The registered manager confirmed the registered provider completed exit interviews to understand why staff did not stay at the home.

The registered manager confirmed they used agency staff and staff rotas showed this usage was high. A staff member said, "In general we've got the same ones coming in."

Staff told us about the induction they received when they first started at the home and were able to describe how they supported agency workers new to the home by working with them during their shift, however there was no documentation to support this. We discussed this with the registered manager who made arrangements to provide a formal induction for these workers.

We asked the registered manager how they were assured agency workers had the right skills and knowledge to support people living at the home. The registered manager told us they relied on the agency providing appropriate staff but did not check this. Since our discussion the registered manager had asked the agency for workers' profiles before agreeing to let them work at the home.

The registered manager told us additional recruitment had been undertaken and this included recruitment for bank staff so that people living at the home could be supported by a more consistent staff team.

The service had an infection control policy; this gave staff guidance on preventing, detecting and controlling the spread of infection. This included the use of personal protective equipment (PPE) including disposable gloves and aprons. Staff received training in infection control to ensure they knew the correct processes to follow.

We saw up to date records relating to safety checks for the premises, for example in relation to operation of equipment, gas safety, electrical wiring, water storage and fire alarm testing.

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 the registered manager to identify patterns or trends, enabling changes to be made to people's care and support to reduce future risk of injury. There was no evidence the registered manager had used these to improve the service, for example, by considering lessons learnt and implementing changes across the home. The registered manager had acted to reduce individual risks for people living at the home. We did not see evidence these trends had been shared with staff. We discussed this with the registered provider who told us they were providing support for the registered manager to do this.

Requires Improvement

Our findings

Prior to people moving into Roberttown Care Home, people's physical, emotional and spiritual needs were captured during a pre-assessment process. This information was used to develop person-centred care plans. These were detailed and were written with the involvement of people and their relatives. A relative told us, "[We were] involved in the assessment before [relative] moved in and [we have] had input into the care plan with staff." However, people's daily records did not show people's wishes had always been followed. For example, one person's care plan said they would like a daily paper but it did not say which daily paper and we did not see any evidence this had been provided. One person's pre-assessment recorded their preferred name was different to the name recorded on official documents. Despite this being the person's preference, nearly all records in the home called the person by their 'official' name and not the name the person preferred. We brought this to the attention of the registered manager who told us they would review this.

We looked at whether the service considered and respected people's human rights and their individuality under the protected characteristics of the Equality Act 2010 and found that home considered these in their assessments of people's needs and when reviewing these.

People were offered choices and consented to their care and support arrangements. The home asked and recorded people's consent to care and support and this was decision-specific. In some instances there were no dates recorded for when people had consented and we brought this to the attention of the registered manager.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. For

example, the provider complied with conditions placed on people's DoLS authorisations. One authorisation had a condition that said the home must keep a record of what activities the person had been offered, refused and encouraged to take part in, with regards to promoting stimulation in and out of the care home. This person's daily activities record contained these details.

The registered manager and senior management team had a good understanding of the MCA and had followed requirements to submit applications to the supervisory body. However the registered manager was not aware if any of the people they supported had a Lasting Power of Attorney [LPA] in place. This was discussed with the registered manager who confirmed they would address this matter.

Staff were well-trained and received regular training to keep them up-to-date. For example, staff were knowledgeable about how to use equipment correctly to keep people safe and were able to describe best practices and the reasons for these. A relative told us, "Some days [person's name] gets a bit confused but the staff have the skills they need to look after [them] well." The registered manager explained how the provider sent them update emails about current legislation and national guidance.

New staff with no previous experience in the caring profession completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff did not have access to regular supervisions or appraisals. A staff member told us, "I've never had an appraisal." Another staff member said, "I haven't had any supervision but I've been told to go to [registered manager] if I have any problems. I haven't had to do this because everything seems fine." The provider's policy said staff should receive an annual appraisal however out of 28 staff working at the home only eight had received an appraisal within the last 12 months. The provider's policy said staff should receive a quarterly supervision however most staff had only received two supervisions in 2018. The registered manager told us, "They [supervisions and appraisals] will be getting caught up before the end of the year."

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to ensure staff received regular supervision and appraisals to enable them to carry out their duties effectively.

People were able to choose what to eat for each meal and alternatives were available if they changed their mind. Meals were well presented and people were encouraged to eat. Breakfast was prepared individually so food was freshly made when people were ready to eat their breakfast. The cook was aware of people's dietary needs and allergies however there was no information in the kitchen about people's likes and dislikes although these were recorded in people's care plans. The cook spoke about the importance of ensuring people who needed a pureed diet having their meals prepared and moulded so the meal looked appetising. During lunch we observed one person who used the service being encouraged to set and clear the table. This supported their independence and social needs.

A relative told us, "The food is good. [Person's name] gets what [they] need and seems to enjoy the food. The dietician came last week because the home was concerned…[they] weren't gaining any weight." Another relative said, "[Person's name] does better with their food here than they did at home!"

Each table had tablecloths, napkins and fresh or silk floral arrangements. Sachets of condiments were available on each table however we observed these weren't used and these can be hard for people living with dementia to open unaided. Drinks were freely available during meals and there was a 'drinks station' and a fridge 'snack station' in each dining area however the choice of snacks in the fridges was sparse and

limited.

People's food and fluid intake was recorded and people's weight was monitored on a weekly basis. Where there were concerns about people's weight, a referral had been made to a dietician or GP.

At the start of each shift a handover took place. Handover sheets were detailed and contained a snapshot of information about each person as well as information about the care and support they had received during the shift. This meant staff received up-to-date information to ensure people were supported appropriately.

People's records detailed when advice had been sought from health professionals and when staff had requested visits. A relative told us, "There was a time when [name of person]'s glasses broke. [Staff] rang the opticians and got a new pair straight away." Whilst medicines were being administered during the morning of our first visit the senior care assistant noticed someone was unwell and asked if they wanted a visit from their GP. The person was gently encouraged to have a GP visit and the GP visited that afternoon.

Each person's bedroom was individually decorated, many with personal ornaments, furniture and family photographs. Bedroom doors recorded the name of the person who lived there and a picture or photograph relevant to them. This can help people to identify their own room. Communal toilets and bathroom doors were easily recognisable with signs and pictures to indicate the purpose of the room.

The home has communal lounges and dining rooms on the ground and first floor. The lounge and dining area on the first floor was sparsely decorated. The registered manager told us of improvements they would like to make to some areas of the home. They hoped the dementia garden would be ready by Easter.

Good

Our findings

People told us the staff were caring. One person commented, "The staff are all lovely and know what they're doing. They're very caring." A relative said, "Everyone here is lovely. They do everything as far as they can." Comments from staff included, "All of us staff here are caring. We know what to do and then make sure it's done", "I always care for people like I'd want them to care for me" and "I want to give people the best care we can."

Staff interactions with people were caring and personalised. We observed staff spending time chatting with people about their hobbies and memories of travel. Staff relayed one of the conversations to a visiting relative who appeared delighted to know staff were spending time with their relative. We observed another person who was anxious about living in the home being given quiet and supportive reassurance. Staff were very patient and promoted people's independence when supporting them. For example, one person was given discrete choices about when, where and how they wished to be supported to the toilet.

We saw examples throughout the day where staff encouraged people to make their own choices. For example, we observed staff asking, "Would you like to find a seat?", "Would you like me to help you?" and "Would you like your glasses on?"

People's independence was encouraged by staff. For example, one staff member said, "You're doing really well today." Another staff member, after supporting someone to cut up their meal said, "There you are, darling, try and eat it, it's beautiful."

Staff maintained people's privacy and dignity and were able to describe how they would do this. A staff member said, "I give choices...I close the door for personal care." Another staff member told us, "I shut the door, make sure the curtains are closed, and use a towel to cover modesty."

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 to enable them to voice their opinions and promote their independence. 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.

Records were not always stored securely and so people's confidentiality may have been compromised. Care records were stored in the ground floor office. The office door was unlocked and open some of the time during our visits, which meant it was accessible to anyone. The cupboard where the care plans were stored

had a padlock, but on two occasions this was left open and unlocked.

Good

Our findings

Staff were knowledgeable about people's individual needs. A staff member said, "One person thinks that they are at work and so we encourage [them] to lay the tables and clear away after mealtimes and [they] seem to enjoy this." However, this staff member also said, "I've no idea what's in the care plans I have not read them…I expect they tell me about people's backgrounds and illnesses." We brought this to the attention of the registered manager who told us they were considering how to encourage staff to spend more time reading people's care plans.

Care plans provided detailed information about how people should be supported to maintain their independence. For example, one person's care plan for personal care described the support to be given to maintain their independence.

Care plans did not always contain up-to-date information about people's needs. For example, there was a note to say tomato soup made someone sick but the care plan had not been updated with this information. Care plans we looked at showed a lack of accurate recording of people's continence needs. For example, people's continence needs assessments were reviewed monthly but changes weren't reflected on the care plans.

Daily record logs were written by the senior care assistant on shift part-way through the shift. For example, many daily records were completed at 3am but the night shift did not finish until 8am. We asked the registered manager and a senior care assistant how they ensured the daily logs were accurate. We were told the senior care assistant asked staff about each person before they completed their daily log. We discussed this with the registered manager who told us they would consider alternative methods of ensuring more accurate recording the daily care and support people received.

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.
People's communication needs were recorded in their care plans which included details of how staff should communicate with people. For example, one person's care plan described how they would not use their call bell to call for assistance. Another person's care plan recorded that they did not speak English. Staff had produced a folder with words and phrases in the person's language so they could speak with the person and the person could point at phrases to show what they wanted to say. A staff member explained how they had

used an ipad to translate and relay information. They said, "At first the person found it frustrating, but we quickly supported them and everything was fine."

We spoke with the activities co-ordinator who told us they made sure they supported each person with an activity or a conversation at least once per day. Activities records confirmed this. The activities co-ordinator was very knowledgeable about people and their individual needs. They gave an example of a person who enjoyed sitting in the garden and how they made sure this happened requlary. There was recognition of the importance to people of maintaining a "rhythm and routine" in their daily lives as well as encouraging them to try new things.

There were plans to start each day with some gentle movement and perhaps some meditation. On the second day of our inspection visit we observed people enjoying a guitarist and harpist. People were given information about each tune and participated in singing. People had access to hobbies, such as knitting. One person told us staff bring in wool for them and they knit scarves for winter, including ones with pompoms for children.

People's religious and spiritual needs were supported by two local churches who visited the home each month and provided a service and individual support if people wished.

People told us, "I've never had anything to complain about, no problems…If I did have anything to complain about I would talk to [registered manager], I'm sure [they]'d see to it." A relative said, "If I had any problems I'd go straight to the office and tell them, but I haven't needed to because it's all fine here." Another relative said, "I've no complaints. If I did, I'd speak to [registered manager]. I'm sure [they] would sort it out, or one of the seniors." A staff member told us, "If anyone made a complaint to me I would tell the manager or the senior and they would sort it out."

The complaints policy had recently been updated and was displayed in the home and also contained in the service user guide. We saw three complaints had been received since our last inspection. All three had been investigated and responded to appropriately. The complaints were all recorded in a book, however the registered manager showed us a new complaint form they had put in place to record any new complaints and to ensure the home was meeting data protection requirements. Although the registered manager responded to verbal concerns they did not record these. We discussed this with the registered manager who recognised the need to record these in future.

Care plans showed people were asked about how they would like to be cared for at the end of their life. Where people had expressed a particular wish or preference, this was recorded in their care plan. There was no one at the home receiving end of life care during our inspection. The registered manager told us the home had previously supported people at the end of their life.

Our findings

A staff member said, "Yes, it's well-led here. We have good communication and a good team. You can always talk to the manager when you need to." Another staff member said, "It (the home) seems a lot happier since [name of registered manager] was manager." However, another staff member said, "We don't really get told anything, we're all in the dark, we just look after [people]."

Staff confirmed the registered manager was a visible presence in the home and senior regional managers made frequent visits.

Most staff were confident they could raise concerns. One staff member said, "I'm comfortable with the manager…I'm definitely supported." Another staff member gave an example of how they had been supported by the manager when a person living at the home had upset them. However, another staff member said, "It's very awkward for care staff to say anything to [name of registered manager]."

Another staff member described how they had been supported to work at the home whilst having a health condition which meant they needed additional support. For example, during their interview they were given additional time. This demonstrates the registered manager had considered staff's equality and diversity needs.

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, "I want the home to thrive, I want it to feel like a 'home' home." They explained their ambition was for people to feel Roberttown Care Home was their home and for relatives to feel they could come and go as they pleased. They wanted staff to be proud to work at Roberttown Care Home and for the community of Roberttown to be proud of the care home.

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

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 provider undertook an annual Health and Safety audit which checks the environment of the

home. Where it identified any issues, the registered manager was required to take immediate action to rectify them. The last audit had taken place in February 2018 and actions had been tracked and recorded on the continuous improvement record.

The registered manager undertook a daily walk-round of the home. These were recorded and contained detailed information and actions regarding the day to day running of the home.

The registered manager compiled a monthly report which was submitted to the senior management team. 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 the report contained actions for the registered manager to undertake and these had been completed and recorded.

The registered manager conducted a range of audits on a monthly basis, to monitor the quality and safety of the service. These included checking a sample of risk assessments of people living at the home and medicine administration. The registered manager told us the senior care staff sometimes completed these audits. When we checked a sample of care plan audits we found not all issues had been identified. For example, the type of sling required was not recorded for one person. Medicine audits had not identified dates of opening were missing on some medicines. There were no records of any audits for May, June and July 2018. The registered manager told us these had been completed but was unable to find them.

The registered provider had systems in place to assess and monitor the performance of Roberttown Care Home however these systems were not robust enough to identify and drive all necessary improvements. The provider's systems had not identified the concerns we found in relation up-to-date information for people's care and support needs, and that people's records were not stored confidentially or that records did not always accurately reflect people's current needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; good governance.

Staff confirmed meetings were held on a regular basis. The registered manager told us they tried to aim for one meeting each month. Minutes from the last two meetings contained instructions for staff but did not record staff involvement or whether previous actions had been completed. We asked the registered manager how staff were involved in the running of the home and was told staff were encouraged to speak to the manager individually. Some staff told us they felt intimated by this. We discussed this with the registered manager who told us they would consider other ways for encouraging staff input into how the home is managed.

People and their relatives had a say in how the home was run. 'Residents and relatives' meetings took place twice a year. Minutes showed actions from these were completed and confirmed at the next meeting.

A person living in the home had been involved in interviewing for a member of staff, which they had enjoyed. The registered manager told us they planned to ask more people to participate in staff recruitment interviews.

The home had developed links with a local school and pupils had visited the home at Christmas and Easter to sing to people. People had also been able to visit a primary school to watch their Nativity. The registered manager described how they were setting up a buddy system with another local school for people living in the home and pupils to get together individually if wished.

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 People's emergency evacuation plans were not always up-to-date or contained accurate information. There was a lack of consistency about where information was recorded in people's care plans. There was a lack of consistency about where information about where the application of topical creams was recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Concerns about people's safety was not always documented. Business continuity arrangements were not robust in the absence of managers within the home. The competency and skills of agency workers was not checked. People's information was not always stored securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Most staff had not received regular appraisals or supervision.