Royal Bay Care Homes Ltd

Royal Bay Residential 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?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Royal Bay Residential Home on 27 February 2018. Royal Bay Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Royal Bay Residential Home is registered to accommodate up to 42 people, some of whom were living with dementia and other chronic conditions. There were 31 people living at the service on the day of our inspection. We previously inspected Royal Bay Residential Home on 24 April 2017 and found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, some improvements had been made, but we identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was not in post. 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 and associated Regulations about how the service is run. The service was run day to day by a manager who had not yet submitted an application to register with the CQC.

People's medicines were stored safely and in line with legal regulations and people received their medication on time. However, safe procedures for the administration of the medication were not routinely being followed, which placed people at potential risk of receiving their medicines incorrectly.

Risks associated with people's safety were not always identified and managed appropriately. Staff did not routinely take appropriate action following accidents and incidents to ensure people's safety.

People's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times.

There were some arrangements in place to meet people's social and recreational needs. However, activities were not routinely organised in line with people's personal preferences.

We saw that information had not always been updated in people's care plans to guide staff on how to deliver care and did not always reflect the level of care people were receiving. Furthermore, some people's assessed plans of care were not being followed.

The provider undertook some quality assurance audits to ensure a good level of quality was maintained. However, these systems had not fully ensured that people received a consistent and good quality service that met individual need. People were not actively involved in developing the service. Other than the complaints process, there were no formal systems of feedback available for people, their friends or relatives to comment on the service and suggest areas that could be improved.

Up to date policies and procedures were not readily available to provide clear guidelines for staff to follow.

We have made a recommendation about systems being implemented to comply with the Accessible Information Standards (AIS).

People were cared for in a clean, hygienic environment and infection control protocols were followed, and their individual needs met by the adaptation of the premises. People were being supported to make decisions in their best interests. Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia and managing behaviour that may challenge others. Staff had received supervision meetings with their manager.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not consistently safe.

Potential risks were not identified, appropriately assessed and planned for. Medicines were not always managed and administered safely.

Staff understood their responsibilities in relation to protecting people from harm and abuse. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

People's individual needs were met by the adaptation of the premises.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not routinely offered choices in relation to their care and treatment. Their privacy, dignity and independence was not always respected or promoted.

People were supported by kind and caring staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not accurately record people's likes, dislikes and preferences. Staff did not have up to date information that enabled them to provide support in line with people's wishes.

People were not supported to take part in meaningful activities.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems of audit and quality monitoring did not always identify areas that required improvement. Formal systems to obtain feedback were not in place.

Staff were aware of their responsibilities in relation to whistleblowing.

People, relatives and staff spoke highly of the service and the manager.

Royal Bay Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 27February 2018 and was unannounced. We inspected the service due to information of concern we had received. The inspection team consisted of four 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 for this inspection was an expert in care for older people.

On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. Some people could not fully communicate with us due to their condition, however, we spoke with seven people, three relatives, three care staff, the chef, the deputy manager, the manager, a member of ancillary staff and the provider. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including six people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 24 April 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, however at this inspection we identified further breaches of the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified concerns in relation to the moving and handling practices of staff. Improvements had been made and we saw staff assisting people to move using a variety of hoists and stands. We noted there were enough staff do this safely and staff were evidently competent in managing this and treated people with dignity and respect whilst undertaking it. A member of staff told us, "We have manual handling training which includes hoists, how to use it correctly and how to manoeuvre it, it allows us to keep the residents safe".

People said they felt safe and staff made them feel comfortable. Everybody we spoke with said they had no concern around safety. One person told us, "Yes staff are very good, they look after us we do not have any problems". Another person said, "I would say safe and happy, it is getting me through the period of recovery to get home". However, despite the positive feedback, we identified areas of practice in need of improvement.

There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. However, the care plans we looked at did not always detail people's changing needs. For example, one person's monthly falls assessment review for the period from January to May 2017 stated they were at low risk of falling. However, during this time they had actually fallen four times, three of which resulted in injury and subsequent treatment. We did not find evidence in the care plan that action had been taken or risk assessments reviewed to reduce risk in the future. Staff did not routinely take appropriate action following accidents and incidents to ensure people's safety. For example, it was recorded in another person's care plan they had fallen six times. However, accident and incident recording only reflected the person had fallen four times. We also did not see any specific details and follow up action to prevent a reoccurrence. We could not see that subsequent action was shared and analysed to look for any trends or patterns prevent reoccurrence.

We looked at the management of medicines. Care staff were trained in the administration of medicines. We observed medicines being administered sensitively by a member of staff. They administered them to people in a discreet and respectful way. However, on two occasions after giving people their medicine, the member of staff did not stay with the person to ensure they had taken it safely. Care home staff should administer medicine to people at the point it should be taken and stay with the person to establish whether the medicine has been taken or refused. This is in order to be able to complete an accurate record of a person's medicine usage. Additionally, we were told that one person had been administered a controlled drug as part

of the morning medicines round. Controlled drugs require that staff record when the drug was administered, and another member of staff also witnesses and records this. We saw that the record to show when the controlled drug had been administered had not been completed. A member of staff told us they would complete the record straight away and find another member of staff to witness this. However, the drug had been administered several hours earlier and the purpose of the witness is to verify this at the time, not subsequently later on in the day. Care home staff should complete the medicine record only when a person has taken their prescribed medicine, and the individual record should be completed before moving on to the next person. This is to reduce the risk of medicines being recorded incorrectly. We raised this with the manager, who was aware this was not following the correct procedure for the administration of the medicines. Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. We also saw that auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge.

Nobody we spoke with expressed any concerns around their medicines. However, the above issues around administering and recording medicines and assessments of risk to people are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014). We have identified these as areas of practice that need improvement.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

Staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training and this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse were displayed around the service for staff and people. Documentation showed that the provider co-operated with relevant stakeholders in respect to any investigations of abuse.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told agency staff were used and existing staff would also be contacted to cover shifts in circumstances such as sickness and annual leave. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "I will press my bell and a carer will come". Another person added, "More than enough [staff] really". A member of staff said, "There hasn't been enough staff recently. We use a lot of agency staff at the moment, so there are enough on shift". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the service and its equipment were clean and well

maintained. People told us that they felt the service was clean. One person said, "Yes it's clean, as far as I know". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves had been readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. Infection control training was mandatory for staff, and records we saw supported this. There were procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Good

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "I love them all, yes they do listen to me".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment was used to develop a more detailed care plan for each person which detailed the person's needs. They included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan.

Staff had received training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. One person told us, "The carers are excellent". Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people living with dementia and managing behaviour that may challenge others. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff confirmed that formal systems of staff development including one to one supervision meetings were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race,

religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, community nurses and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured that when people were referred for treatment that they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. We saw if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "Excellent, I have had four bad meals out of the six months I have been living here". Another person said, "It's good on a whole, occasionally we have to complain". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was monitored, with their permission and staff stated that any specific diet would be accommodated should it be required.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we identified areas of practice that required improvement in relation to people's privacy being respected. We saw that improvements had been made. However, we identified further areas of practice that need improvement.

At the last inspection the doors of people's rooms had windows in them that were covered by a venetian blind. Some of these blinds were broken, which had compromised people's privacy. At this inspection we saw that the provider was in the process of replacing all the doors with new doors that contained no windows. Furthermore, in relation to people's privacy being upheld, we saw areas of good practice. For example, care staff always knocked before entering someone's bedroom. Some of the feedback we received from people was very positive around the care staff and comments included, "Yes, they always they knock before they get in". Staff discussed people's care needs in a respectful and compassionate way and they were able to describe how they maintained people's privacy.

During the inspection we saw that people were not routinely offered day to day choices around their care, for example how and where they wished to spend their day. They did not always have their independence promoted, and some had their dignity compromised. For example, in the lounge, we observed one person ask a member of staff to assist them to go to the toilet. The member of staff said, "In a minute". Ten minutes passed and the person continued to say they needed to go to the toilet and that their stomach was hurting. A further 10 minutes passed and a member of the inspection team intervened to ask another member of staff to assist the person. This member of staff said, "Ok" and left the lounge, but did not return. Eight minutes later another member of staff came into the lounge and a member of the inspection team had to intervene again to ask them to assist. The person was then helped to the bathroom, 28 minutes after initially asking. In relation to choice, feedback we received was mixed. One person told us, "Yes on the whole I get choices and if I don't agree with the staff I will say it". Another person said, "I get choices within reason". However, one person told us, "No they don't [offer me choices]". A further person added, "No they don't ask me how I like things to be done, they are in and out before you can say anything".

When people enter a residential care setting, this effectively becomes their home. It would not be unreasonable for people, when at home, to wish to watch television in the lounge. We did not observe any 'tele battles' taking place as part of the inspection to Royal Bay Residential Home. However, it is recognised that people had televisions in their rooms and we have amended the report to read: 'We saw that staff did not spend a great deal of time in communal areas with people, or having many personal interactions. For example, we observed nine people sitting in the lounge from 10:15am until 10:55am and no staff were present. People had access to televisions in their rooms, however, throughout the day people in the lounge were not offered to have the TV or radio on and sat in silence for most of the day. We asked one person whether they would like to watch the TV. They replied, "Yes it would be nice". A member of staff told us, "We have the time to make sure people get care, but we don't have time to sit down with them". People's independence was also not routinely promoted. We saw one person being assisted by two members of staff into the lounge. The staff were caring and kind, offering reassurance and assisting the person to transfer and sit down in a safe way. However, once the person sat down their walking frame was removed and stored in

another room. We asked a member of staff why the walking frame had been taken away from this person and they replied, "I am new here, I just do what everybody else does". This person could not mobilise without the frame and would have needed to ask for it to be able to move, rather than being independent. Furthermore, in the lounge we saw that one person wanted to get up. They were told by a member of staff to sit down and was prompted to sit back down in their chair. The member of staff then placed a table in front of the person restricting them from getting up. The person said, "I wanted to pass on a packet of tissues", but this comment was ignored by the member of staff.

A fundamental part of providing people with dignity in care is ensuring that as far as possible, they have choice and control in what they do and where they would like to spend their time. When a person enters a residential care setting, this service effectively becomes their 'home'. Unless a risk was too great, people within their own home should have their independence promoted and would not be restricted in respects to when, where and how they could enjoy their day.

The above evidence demonstrated that people's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

Despite the concerns identified above, it was clear that staff demonstrated a commitment to providing compassionate care. Most of the interactions that took place between people and staff were positive. From talking with staff, it was clear that they mostly knew people well and had a good understanding of how to support them and communicate with them appropriately. Staff gave us examples of people's individual personalities and character traits. One person told us, "The staff and senior are brilliant". Another person said, "Yes, the staff and I get on very well, I am very pleased". We also saw that visitors were welcomed to the service. People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us, "A Catholic priest visits the home".

Requires Improvement

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "I am able to tell staff what I want and don't want and they listen". However, care was not routinely personalised to the individual, and we saw several examples of people's preferences not being met. We saw examples of people not being supported to have a bath when they had chosen to. On the day of our inspection it was recorded that five people were due to be supported to bathe. However, by the end of the inspection, nobody had received a bath. We raised this with the manager, who agreed that it would be unusual for five people to refuse a bath in one day.

Staff undertook an assessment of people's care and support needs before they began using the service. The pre-assessments were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. The service had researched and begun to implement an electronic care planning system. Paperwork confirmed people or their relatives were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews. One person told us, "The care plan was done with my input". The care plans were detailed and gave descriptions of people's needs and the support staff should give to meet these. Each section of the care plan was relevant to the person and their needs. However, in three care plans that we looked at, we saw that information had not been updated to guide staff on how to deliver care. For example, one person had been identified as suffering weight loss on admission to the home. As a consequence, close observation of their nutritional status was needed in the form of the Malnutrition Universal Screening Tool (MUST), to be used monthly. 'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. However, we noted this had only been completed three times in the seven months since July 2017. On each of these occasions, the MUST indicated the person was at high risk. Another person suffered from a medical condition which meant they had severe difficulty breathing, and required continuous oxygen therapy. Their 'breathing' care plan stated the goal was to maintain satisfactory respiration rates of between 16/20 per minute. We did not find any recordings of respiration rates in the care plan.

Furthermore, some people's assessed plans of care were not being followed and did not always reflect the level of care people were receiving. For example, one person lived with dementia. Their dementia care plan had outlined a number of steps staff could take to improve their quality of life. These included, the person's name and photograph to be put on their room door, a picture in their room to show when it was night or day, a pictorial guide on their toilet door, the day and date displayed in their room, personal photographs of family and friends to be put in their room and the removal of mirrors in their room to help avoid confusion and distress. We saw that none of these had been done. Four people's care plans were not person centred. Their choices and preferences were not consistently documented and personal histories were very limited or missing. For example, one person's care plan stated they, 'Enjoyed bingo and having their hair and nails done'. We did not find anything else in the care plan to tell us about this person. There was a large document entitled, 'Memories-Your Life, Your Story, Your Way' which was blank, as was the same document for all but one of the care plans we looked at.

On the day of our inspection, there were not appropriate arrangements in place to meet people's social and recreational needs. A member of staff organised a quiz in the lounge for people in the afternoon, however people spent most of their time sitting in their rooms or the lounge. During the course of the inspection we found there was no opportunity for people to enjoy social activity or stimulation, or be supported to go out. The manager told us that there was an expectation that staff set aside time to visit people who stayed in their rooms on a one to one basis. However, this was not observed taking place. Apart from the delivery of individual care, we saw little other contact from staff with people who remained in their bedrooms. We asked people and their relatives what they thought of the activities at the service. One person told us, "You get the sheet with all the activities, but I don't go". Another person said, "We get a weekly planner very rarely in the lounge. There is exercise, music, craft and bingo". We looked at the activities planner for February and saw that 12 mornings and 10 afternoons had no activities planned, there were also no activities planned for weekends. It is important that older people in care homes have the opportunity to take part in activities, including activities of daily living, that helps to maintain or improve their health and mental wellbeing. They should be encouraged to take an active role in choosing and defining activities that are meaningful to them.

The above evidence demonstrated that we could not fully determine that people always received the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Nobody at the service who received funding had specific communication needs. However, staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. However, staff were not aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I will go to the people in charge, managers and deputy managers". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 24 April 2017, the provider was in breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had not submitted notifications in line with the Commission's registration requirements. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, however at this inspection we identified breaches of the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, the provider had not submitted notifications in line with the Commission's registration requirements, and notifications of death had not been routinely submitted. At this inspection we checked and saw that the required notifications had been sent.

People and relatives spoke highly of the staff and felt the service was well-led. However, despite the positive feedback, we identified areas of practice in need of improvement.

The provider undertook some quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety and infection control. The results of which were analysed in order to determine trends and introduce preventative measures. However, further quality review and auditing systems needed to be introduced. For example, systems to identify that best practice in relation to medicines was not being followed, care plans and risk assessments were not accurate and people's dignity was not always respected were not robust and had not prevented these concerns taking place. Providers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents. The information gathered from regular audits, monitoring and feedback is used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered and minimise risks for people.

People were not actively involved in developing and improving the service. Other than the complaints process, there were no formal systems of feedback available for people, their friends or relatives to comment on the service and suggest areas that could be improved and residents and relatives meetings had not routinely taken place. Having formal systems of feedback enables providers to receive a snapshot of what is important to people, what is going well and what could be improved upon. Analysis of feedback enables providers to demonstrate the quality of their service, create actions to respond to feedback and drive improvement.

Policies and procedures available for staff to use were not up to date and were based on previous regulations. We raised this with the manager, who was aware that the policy and procedure documentation was out of date and stated that they wished to implement new policies and procedures in line with current legislation and best practice.

The above evidence demonstrated that people were placed at risk as the provider did not have robust systems or effective systems to monitor and improve the service. This is a breach of Regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

People, relatives and staff spoke highly of the delivery of care and felt the service was well led. One relative told us, "The new manager seems very approachable and has made a point of introducing themselves". Another person said, "I think most of the staff like working here, they are dedicated". A member of staff said, "I like working here because of the people and the residents". In relation to the service and the manager, staff told us they felt supported and that improvements were being made. One member of staff told us, "The new manager is great and things are improving a hell of a lot". Another member of staff said, "I feel supported by the manager, deputy and the directors. We have regular manager meetings set up by the manager which are open discussions. It helps us to get any issues out in the open. The culture is changing from an uncaring one due to a new approach and some new staff". A further member of staff added, "The manager is really friendly and their door is always open. I am confident she will make the changes needed. She knows what she is talking about and what she is implementing is good. We need to get back to being a good care home".

We saw that the service also liaised regularly with the Local Authority and the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. Additionally, the service engaged with the local community and a visit from a local school had been arranged to spend time with people.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of equality, diversity and human rights gained through training and detailed policies and procedures. Feedback from staff indicated that the protection of people's rights was embedded into practice.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that the care and treatment of service users was appropriate, met their needs and reflected their preferences. (9)(1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that service users were treated with dignity and respect at all time. (10)(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured they had done all that was reasonably practicable to mitigate risk and manage medicines safely. 12 (1)(2)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured they operated effective systems and processes to make sure they assess and monitor the quality of the service, drive improvement and obtain and act upon feedback. (17)(1)(2).