RochCare (UK) Ltd

Royley House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 13 October 2016. Our visit on 11 October was unannounced.

We last inspected Royley House in November 2014. At that inspection we found the service was meeting all the regulations we assessed.

Royley House was originally built as a sheltered housing project and is situated close to the centre of Royton, Oldham. In 2000 it was taken over by RochCare Ltd and transformed into a care home for older people, where it provides accommodation for up to 41 people. At the time of our inspection there were 31 people living at the home. Some of the bedrooms were vacant because the owners were undertaking a programme of refurbishment. Accommodation is provided over two floors which are accessible by a passenger lift. Some of the bedrooms have en-suite facilities. Each floor has its own lounge and dining room and there is a large attractive garden to the rear of the property.

The service had a registered manager. 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.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Infection prevention and control measures were not thorough enough. Posters detailing the correct handwashing procedure were not on display and we observed a carer instil eye drops without first washing their hands. We were unable to find evidence to show us that staff had received recent training in infection prevention and control.

Medicines were not managed safely. An action plan put in place following a recent medicines error had not been implemented in full. We found unsafe practice in relation to the administration of insulin.

Staff had an understanding of safeguarding procedures, how to identify signs of abuse and what action they would take to protect people in their care. However we could not find evidence to show that all staff had received recent training in this area.

The registered manager was unable to provide us with evidence to confirm that staff had received appropriate training in order to be able to carry out their roles effectively. However, staff received regular supervision and those we spoke with told us they found it to be helpful.

The home was clean and generally well-maintained, although there had only been a minimal attempt to

make the environment 'dementia friendly'. We have recommended the provider reviews good practice guidance in relation to developing a dementia friendly environment.

We observed some caring and kind interactions between staff and people who used the service. Activities were available for people to take part in.

People were supported to eat and drink sufficient amounts to meet their needs. People were referred appropriately to a variety of health professionals in order to be supported to maintain good health.

Complaints were recorded, investigated and action was taken in response.

Governance systems to ensure that the quality of service provided was regularly monitored were very limited and issues we identified during our inspection had not been picked up by the few checks that were in place.

The registered manager did not have over sight of the day-to-day running of the home and lacked leadership.

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 always safe.

The management of medicines was not carried out in a consistently safe way. Action plans drawn up following a drug error and not been implemented fully.

Although the home was clean, infection prevention and control measures were not thorough. We were unable to find evidence to show that staff had been adequately trained in good infection prevention and control practices.

Staffing levels were sufficient to meet the needs of people using the service. Staff we spoke with had an understanding of safeguarding procedures and how to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was unable to provide us with evidence that staff had undertaken the appropriate training to enable them to carry out their roles effectively.

Staff received regular supervision.

People were happy with the quality and choice of food provided.

People's rights were protected because the Mental Capacity Act (MCA) 2005 Code of Practice was followed when decisions were made on their behalf.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service were complimentary about the staff.

We observed that staff were mostly caring and kind. However we saw two examples where staff did not interact in a reassuring and positive manner with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care plans were person-centred some information was not always up-to-date or thorough enough.

People were provided with information about how to make a complaint and there were systems in place to record and deal with complaints about the service.

A variety of activities were available for people who used the service to take part in.

Is the service well-led?

Inadequate

The service was not well led.

Some confidential information was not stored securely.

There were minimal governance systems in place to monitor the quality of the service provided.

The registered manager lacked over-sight into the day-to-day running of the home.

People using the service and their families were given opportunities to give feedback about the service.

Royley House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 13 October 2016. Our visit on 11 October was unannounced. The inspection team consisted of two adult social care inspectors and a pharmacist inspector. We asked a pharmacist inspector to take part in this inspection as there had been previous concerns about the management of medicines in the home.

Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider and the Provider Information Return (PIR). Notifications are changes, events or incidents that the provider is legally obliged to send us without delay. The PIR asks the provider to give key information about the service, what the service does well and what improvements they plan to make. We also reviewed the inspection report from the previous inspection and contacted the Local Authority (LA) and Healthwatch Oldham to ask them if they had any concerns about the service, which they did not.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined peoples' care records and observed care and support being provided to them in the communal areas, to capture their experiences. We looked around the building, observed a lunchtime meal and watched the administration of medication to check that it was carried out safely.

During our inspection we spoke with one person who used the service, four visitors, the manager and deputy manager, four care staff, a kitchen assistant and the activities coordinator. We reviewed a variety of the home's documentation, including staff rotas, four staff personnel files, complaints records, accidents and incidents reports and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

We looked at the arrangements the home had in place for the prevention and control of infection. We observed staff using personal protective equipment (PPE), including disposable vinyl gloves and aprons and these were available in bathrooms and toilets. Alcohol hand gel was provided at the front door for visitors to use when entering and leaving the building. An infection control audit undertaken by the local authority in April 2015 identified that handwashing posters should be displayed at each communal sink where staff washed their hands. However during our inspection we saw that posters detailing the correct handwashing procedure were not on display in toilets and bathrooms, as they had been tucked behind the mirrors and were therefore out of sight. Two pedal bins were not working properly and two rooms had swing bins rather than pedal bins, which meant staff risked contaminating their hands when disposing of soiled items.

During the administration of medicines we observed a senior carer instilling eye drops without first washing their hands.

At this inspection, we checked the medicines records for six people. We spoke with the registered manager, deputy manager and two senior carers about medicines management. We found all six records reviewed contained photographs of the person who used the service, but five of the records did not have their allergies recorded. Not having allergies recorded increases the risk of medicines being given to someone with an allergy.

Following on from a medicine error in February 2016 when a person did not have their medicine for several days, NHS England had told the home to complete an action plan with deadlines set, to try to reduce the risk of an error happening again. However, the home had not completed the planned actions on time. For example, a deadline to ensure all senior staff were retrained in medicines administration and were competent to give medicines had not been completed and some staff had not been re-assessed. Following our inspection we received written evidence to show that those remaining staff had passed a medicines competency assessment.

The home was unaware of guidance to reduce the risk of choking from accidentally swallowing fluid thickening powder. We saw that thickeners were left unattended in the dining room. Fluid thickening powder should be stored securely out of the reach of people who use the service to minimise the risk of it being accidentally swallowed.

We looked at the systems the home had in place to apply prescription creams. We found that it was not clear who was responsible for applying prescribed creams as the home had two recording systems in place (one completed by carers and a second complete by senior staff). Where people were prescribed several creams it was unclear who had applied which cream, as the records were incomplete and the registered manager and deputy manager were unable to clarify this. This meant it was impossible to tell whether creams were applied as prescribed by the person's doctor.

The deputy manager informed us that a doctor had agreed for two people (who did not have the capacity to make their own decisions) to be given their medicines in a covert manner (hidden, for example in food). Giving medicines covertly requires a 'best interest' meeting between appropriate professionals including the person's doctor and a relative, and the home did not have a record of this having taken place. When we explained the need for a 'best interest' meeting, the deputy manager told us the medicines were being crushed to make it easier for the two people to swallow, rather than because they were being hidden. Care plans did not describe any additional support these people needed when taking their medicines. It was unclear whether medicines were to be crushed to aid swallowing or because they needed to be given in a covert manner when the person refused them. We asked the registered manager to contact the peoples' doctor to clarify this.

During our inspection we identified unsafe practice in relation to the administration of insulin. A person who used the service was supported with their daily insulin injection, which they self-administered using an insulin pen. An insulin pen is composed of an insulin cartridge and a dial to measure the dose and is used with disposable needles to deliver the required amount of insulin. A senior carer told us that it was their responsibility to dial up the correct dose of insulin and give it to the person, who then injected themselves. Prior to this, they checked the person's blood glucose level using a glucometer, to ensure that the level was within the correct limits to administer insulin safely.

We looked at the records the home used to record the administration of insulin and found them to be incomplete. Where the dose of insulin had been altered by a healthcare professional this had not always been recorded correctly so that the information was easily available to staff. We found that signatures were missing on the administration records and that there was no record of where on the person's body the injection had been administered. It is important that insulin injection sites are 'rotated' to prevent the build-up of fat deposits under the skin, which may interfere with the absorption of the insulin. We asked the registered manager if staff had received training in diabetes and insulin administration from the district nursing service when the home had taken over this role in July 2016. The registered manager was unable to tell us, stating ''I couldn't tell you, they might have done''. One staff member we spoke with was able to tell us what action she would take if someone's blood sugar level was dangerously low.

During our inspection we contacted the community nursing service and asked them to take over oversight of insulin administration at this home, with immediate effect.

The above examples of poor infection control practices and unsafe medicines management demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff personnel files to check that robust recruitment procedures had been followed to ensure that suitable staff had been employed to care for vulnerable people. In one staff file we found that no photo identification of the person had been obtained. We asked the registered manager to request this as soon as possible, which they did.

People who used the service told us they felt safe at Royley House. One person said ''I'm treated like royalty'' and a relative commented ''I'm glad my (relative) is in here''

Staff we spoke with were able to tell us how they would identify and report signs of abuse or neglect. When asked what was the thing they most liked about their job, one carer said ''Making sure people are safe''. We were unable to find evidence that all staff had completed recent safeguarding training. However, one carer told us that she had received training and completed a workbook on the subject and we saw a completed copy of a safeguarding training booklet for another member of staff. The registered manager completed the

monthly log of safeguarding concerns which was submitted to the local authority. A quality monitoring inspection carried out by the local authority in April 2016 had advised the registered manager to display the home's safeguarding adults policy on a notice board in the main entrance to the home, so staff and families could view it. This had not been done. The registered manager told us she would take steps to display the policy in the entrance hall.

The majority of people we spoke with felt there were enough staff to meet the needs of people living at the home. One relative told us they were happy with the staffing levels and commented '' You can usually find a member of staff''. However, another person told us that she felt there were not enough staff as people sometimes had to wait too long following a request to be taken to the toilet. She added '' It would be nice if they could have more staff so that they could have more TLC''. One carer commented that she felt the staffing levels were satisfactory for the current lower level of occupancy, but that if the number of people living at the home increased there would not be enough staff. The provider confirmed that if the number of people living at the home increased, staffing levels would be reviewed to ensure residents' needs could be met. During our observation of the lunchtime meal we observed one carer supporting two people with their meal at the same time, as there was no one else available at that particular moment. During our inspection we saw that staff responded promptly to the 'call bell' when people summoned assistance. We concluded during our inspection that there were sufficient staff to meet the needs of people using the service.

We undertook a tour of the premises to check that the building and equipment were safe and that the environment was clean. The home was generally well maintained and decorated and was free from any unpleasant odours. Health and safety checks for the building, for example for gas safety, lift maintenance and emergency lighting had been completed. We were shown some bedrooms that had recently been refurbished and saw that this had been done to a high standard.

There were systems in place to protect staff and people who used the service from the risk of fire. Fire extinguishers and the fire alarm were checked on a weekly basis, and fire drills were held regularly. People who used the service had a personal evacuation escape plan (PEEP) in place, which explained how each person would be evacuated from the building in the event of an emergency.

The kitchen had a Food Standards Agency food hygiene rating of 5, which is the highest rating achievable. This had been awarded in March 2016.

Requires Improvement

Is the service effective?

Our findings

New staff undertook a basic induction period which included some time spent 'shadowing' more experienced colleagues in order for them to become familiar with their role. We saw a copy of the induction training schedule, which included topics such as reporting incidents, introduction to people who used the service, the fire procedure, confidentiality and abuse. There was no indication on the schedule how manual handling training was to be given and assessed and we saw that there was no specific training on infection prevention and control. We asked the registered manager if 'new starters' had received training in infection control and were told that senior carers showed them how to wear gloves and aprons but there was no formal training session. This meant there was a possibility that people were receiving support from staff who did not have sufficient knowledge on infection prevention and control and were therefore at risk of receiving unsafe care.

We looked at the training staff had undertaken to enable them to carry out their roles competently.The registered manager told us that some staff had a NVQ level 2 or 3 in Health and Social Care and that new carers were enrolled on the 'Care Certificate'. These are nationally recognised qualifications for people working in the caring sector.

We asked the registered manager if she could provide us with a training matrix which would show oversight of the level of mandatory training undertaken by staff. However, she was initially unable to provide us with one, commenting that ''Training has slipped''. During the course of our inspection she provided us with a basic training matrix, however this was incomplete. There was no indication as to how frequently mandatory training, such as infection control and safeguarding vulnerable adults should be undertaken. There were a large number of gaps in the matrix making it impossible for us to ascertain who was up-to-date with training. The date for one person's 'infection control' training showed July 2007. The registered manager told us that she was in the process of putting information about training needs onto the computer. We looked at the staff file for one person who had been working at the home for seven months but could not find evidence that they had undertaken any training since they began work at Royley House, although this member of staff told us they had received training in a previous job in the caring profession. The registered manager was unable to confirm if staff supervising insulin administration had received training in this, or in diabetes management. The registered manager told us that she had been reliant on using training provided by the local authority, but that due to recent budgetary constraints within the local authority this was no longer being provided as frequently as previously. However, she had not taken steps to find an alternative training provider and ensure staff training remained up to date and reflective of current best practice.

The above examples demonstrate a breach of Regulation 18 (2) (a) Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervision of staff was carried out around three times per year and staff we spoke with told us that they received regular supervision and that they found it helpful. Supervision is important as it provides an opportunity for staff to review their performance and identify any support they need.

People told us they were happy with the quality of the food. One person said ''The food is marvellous. It's like a first class hotel''. The home operated a four-weekly menu cycle and copies of menus were on display. The menu of the day was displayed outside each dining room. Cereals, toast and a cooked breakfast were offered at breakfast time and a choice of hot meal was served at lunchtime. A lighter meal was provided at teatime and drinks and biscuits were available between meals. Staff told us that if people did not like the choice of meal on offer they could make them something different.

On the second day of our inspection we observed the lunchtime meal in the upstairs dining room where tables were laid with tablecloths and condiments. The food served looked hot and appetising and the portions were ample. During our observation of the lunchtime meal we saw that a carer assisting people with their food did this in a kind and caring manner. However, she was sitting between two people, assisting both of them at the same time as there was no one else available to help. This meant she could not give each person the attention they needed.

People's nutritional requirements had been assessed on admission to the home and were reviewed regularly. People were weighed and a Malnutrition Universal Screening Tool (MUST) score recorded. The MUST score helps to identify adults who are malnourished, at risk of malnutrition or obese. People's weights and MUST scores were recorded monthly in their electronic care files. A graph depicting the monthly trend of each person's weight provided the staff with an easy visual guide for weight monitoring. Where people were found to be losing weight the appropriate referral to a dietician had been made.

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 the mental capacity to take particular decision, any made on their behalf must be in their own interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection the home had submitted ten applications to the Local Authority and was waiting for them to be authorised. The registered manager was aware that she should notify the CQC when she received the authorisations.

During the inspection we checked if staff asked for consent before providing support to people and whether people were able to make choices about the care they received. One relative told us that staff always gained consent from their relative before offering them assistance. Staff gave us examples of how they would recognise that someone had consented to care if they were unable to speak, for example by looking at their body language, or by facial expressions and hand gestures. We saw examples of where staff offered choice to people, such as asking what they would like to eat. However, on the second day of our inspection we saw a member of staff give drinks to people without first asking them which drink they would prefer. We also saw two members of staff move a person from their chair using a portable hoist. They did this without first asking the person if they wanted to be moved. This meant that staff did not always seek consent from people before offering care and support to people.

We saw that there had been some attempt to make the home more accessible to people living with dementia with the use of pictorial signs indicating the function of different rooms, such as the bathrooms and toilets. However this was minimal. There had been no attempt to put any form of dementia signage on people's bedroom doors to indicate who the room belonged to and the décor, in particular on the upstairs corridor was bland, with no contrasting colours to help make doors and woodwork stand out from the walls

and carpet. Department of Health guidance found in the report 'Dementia-friendly health and social care environments' describes the importance of using bold, bright colours to enable people with dementia, and sight problems, to identify different rooms and key features. The registered manager informed us that the area manager was looking into ways of making the home more 'dementia friendly'.

We recommend the provider reviews good practice guidance in relation to developing a dementia friendly environment.

The home had a large, wheelchair accessible garden, which contained furniture, shrubs and plants and a gazebo and provided an attractive environment for people to sit in during the summer months.

People who used the service had access to a range of healthcare professionals, such as district nurses, general practitioners (GPs) and a care home liaison nurse. One person we spoke with told us that they had asked the registered manager to arrange for a dentist to visit their relative, and this had been done. Another person we spoke with told us that they were always kept up-to-date with information about their relative's health. They said '' I am kept well informed''.

Requires Improvement

Is the service caring?

Our findings

We received positive comments about the staff from people we spoke with. These included ''The care she receives is excellent'' and ''The staff are fantastic. They are kind to everybody''. One person told us ''I'm happy here'' and a relative we spoke with said ''They are really attentive to [relative]''. One visitor told us how when their relative was recently admitted to hospital, staff from the home visited [relative] there to check on their progress.

We looked at comments made about the home in the 2015 Relatives Survey. In response to the question '' Do you think that this home is a good place for your relative to be living'' we saw that all those who responded (17 out of 41 surveys distributed) had answered 'Yes'. One person had written ''Overall Royley House has provided a comfortable, caring environment for my relative. They are always settled, happy and staff can be very friendly and supportive''. People had commented in the survey that they were made to feel welcome when they visited their relatives. One person said '' I am always made to feel welcome when I visit and enjoy the light hearted conversation with staff who are always hard working, friendly and committed''.

We saw people who used the service generally looked clean, well presented and groomed. Their clothes were well kept and clean. However, we saw that sometimes there had been a lack of attention to personal appearance, for example in relation to facial hair. We asked staff to ensure this was attended to where appropriate.

During our inspection a hairdresser was in attendance and the activities coordinator told us that she regularly held 'pamper sessions', such as hand massage and finger nail painting.

We observed staff interactions with people and saw that they were mostly caring and kind. For example we saw staff walking with people along the corridors, chatting and asking them how they were. A person who had become distressed was comforted by a carer, who sat with them, held and patted their hand and talked soothingly to them. We saw staff singing and laughing with a person. One relative told us ''I am very impressed with the patience of the staff''.

However during our inspection we saw two examples where staff did not interact in a positive way with people. We observed a carer supporting a person to have a drink. They needed to be given this on a teaspoon, due to swallowing difficulties. The carer helping the person did not speak to them at all during the time they were supporting them. In another example we saw two carers using a portable hoist to lift a person out of their chair, a manoeuvre which can be uncomfortable and unsettling. Although one carer spoke a few words to the person, neither of the carers offered any reassurance, or gave the person an explanation of what they were doing. We spoke to the registered manager about this lack of interaction during hoisting and subsequently we saw that staff offered reassurance to a person they were lifting in this manner.

We were unable to find evidence to show that staff had received recent training about 'privacy and dignity' although some staff had covered this area in their NVQ level 2 and 3 course. It was not covered in the staff

induction programme. However, staff we spoke with were able to tell us ways in which they ensured people were treated with dignity and their privacy respected. Examples staff gave us included covering people while supporting them with personal care and always knocking on people's doors before entering their bedrooms. One person who used the service said ''They always knock on my door'' and a relative told us ''I'm impressed with the [way they treat people with] dignity''. The registered manager told us that privacy and dignity were discussed during staff meetings and in staff supervisions.

The home had completed the 'Six steps to success – Northwest end of life care programme for care homes'' during 2014. This aims to provide staff with the knowledge to offer high quality end of life care to people using the service. Support to care staff, and symptom control management were provided by the District Nursing Service. We saw that people's end of life wishes were documented in their care plan. The home had a dedicated room available for people who wanted to stay overnight at the home when their relative was approaching the end of their life. At the time of inspection this room was in the process of being refurbished.

Requires Improvement

Is the service responsive?

Our findings

Prior to moving to Royley House a pre-admission assessment was carried out by the registered manager. This assessment usually took place at the person's home or if the person was in hospital they were assessed there. People and their relatives were encouraged to visit the home prior to accepting a place at Royley House and those we spoke with felt this was helpful.

All people who used the service had a 'key worker'. The key worker was responsible for helping ensure that the person had everything they needed in terms of personal toiletries and clothes. The registered manager told us that being a key worker meant '' getting a bit closer to that person, trying to build up a more personal relationship''.

We looked at the care records of four people who used the service and saw that assessments were comprehensive, containing information about the person's medical and personal history. The information enabled senior staff to devise support plans which were person-centred. However, one of the support plans we viewed did not contain sufficiently detailed and up-to-date information, despite having been reviewed regularly. The person was receiving support with diabetes management but the support plan did not explain what symptoms the person might display if their blood sugar level was too low or what action a carer should take if this was the case. In addition, information about the level at which the carers should contact the diabetes service in relation to a high blood sugar level was not correct. There was no information in the support plan about where on the body the insulin injection should be given.

The home had introduced an electronic documentation system in October 2015, which staff accessed using their own password. Information detailed on the computer included care and risk assessments, weight charts, food records and support plans. The system used a selection of pre-programmed stock phrases, which were then enhanced by free text in order to make the documents personal to each person who used the service.

We asked the registered manager if staff were confident about using computerised care plans. She told us that she knew one person did not like using them, but because this person had been working at the home for a number of years she felt she knew people's care needs. One carer we spoke with who had been working at the home for 6 months told us that she had not yet viewed care plans as she was not confident at using a computer. This meant there was a possibility she did not have up-to-date information about peoples' care needs. Charts used to record, for example, someone's position change or their fluid intake were still recorded on paper copies. Those we checked had been completed correctly.

We were told that senior carers attended a 'handover' between shifts, where information about people's health and care needs was shared. Any changes to peoples' needs were then cascaded to the other carers. This information was also written in a communication book which was available for all staff to read. One carer commented that they always asked a senior member of staff if there had been any changes to people's needs, but that sometimes they did not receive the relevant information in a timely way. Another carer told us they were only informed if specific things had changed, for example, if someone was ill. This meant that

information about changes to peoples' care needs was not always shared in way that ensured all staff were made aware of the changes promptly.

People we spoke with were happy with the level of involvement they had with their relative's support plans and commented that senior staff were always available to discuss their relatives care when they visited. One person said ''It's an ongoing dialogue''.

The home employed an activities coordinator who worked 20 hours per week, over four days. Activities offered included arts and crafts, bingo, dominoes, quizzes and singing and on special occasions, such as people's birthdays, a party was held. In the warm weather activities took place in the garden. The activities coordinator told us that in addition to organised group sessions she also spent time with people on a one-to-one basis. Relatives we spoke with were happy with the activities on offer. People's spiritual needs were met by a visiting priest, who offered communion and took religious services, such as for Remembrance Day.

We looked at how the service managed complaints. Details about the procedure for making a complaint were displayed in each bedroom. We saw that all recent complaints had been investigated and dealt with appropriately.

Inadequate

Is the service well-led?

Our findings

Staff and people who used the service described the management team as being ''Supportive and approachable''. A carer said ''They are approachable and listen to you, they take into account your personal circumstances''. One visitor told us the registered manager, "Is a lovely lady'' and another said "She is a very caring person.'' However, one relative expressed concerns over the registered manager's management skills, saying, ''She's not quite got a grip on it''. Staff told us that they worked well together as a team and one member of staff who had recently started working at the home described other staff members as being ''Really caring''.

At the time of our inspection there was a registered manager in post who had been registered with the CQC since October 2010. The registered manager was assisted in the running of the home by a deputy manager, and more recently by an area manager, who had been in post for two months. We did not meet the area manager during our inspection. On several occasions during our inspection we found that, when asked for information, the registered manager referred us to the deputy manager, as she was unable to provide the information herself.

We looked at the governance systems to see how the home monitored the quality of service provided and found checks did not provide oversight of the day to day running of the home.

We asked the registered manager if she carried out any audits of the care documentation and electronic care plans to ensure that they were completed correctly and were up-to-date. She advised us that she did not.

The area manager, who had been in post for two months prior to our inspection, had recently introduced a medicines audit and we saw that this was being carried out on a weekly basis. Prior to its introduction there had been no system in place to check that medicine management was carried out correctly and safely.

We asked the deputy manager what quality assurance checks they carried out on the home's glucometer to ensure that it was functioning correctly and producing accurate readings. She explained that they sent off a control sample each month to a company who checked the accuracy of the reading. The last test had been completed on 8/8/2016. After this check they had been informed by the company that they were no longer providing this service. However, the home had not taken steps to find an alternative method for checking the accuracy of the machine. This meant the home could not be sure the machine was producing readings which accurately reflected a person's blood glucose level. Recent readings had been used by the diabetes service to adjust an insulin dose.

On reviewing the daily and weekly cleaning schedules we found that they had not been completed fully and the records were jumbled and disorganised. We saw a comment made in a local authority infection control inspection carried out in June 2015 that stated ''Manager has now devised a system to ensure that there is evidence of cleaning in all areas''. We asked the registered manager if she checked that cleaning staff completed these records and she told us she did not. This meant the registered manager had failed to

monitor the standard of cleanliness with the home. The registered manager told us she carried out an annual 'bedroom' audit to check on the standard of furnishings within the home. This had been completed in March 2016.

The registered manager had not undertaken a risk assessment following the employment of a person who there had been previous concerns about. This meant the registered manager had not ensured vulnerable people were appropriately protected. Subsequent to our inspection the registered manager provided us with a suitable risk assessment.

We saw that some confidential documents were kept in the entrance hall. These were accessible to people who used the service and visitors, as they were not locked away. The documents included information about people's medical conditions and doctors' letters. We asked the registered manager to remove them from the hall and store them securely, which she did.

Following a medicines error in February 2016 which resulted in a complaint being made to NHS England, the home was asked to provide an action plan to reduce the likelihood of a similar error occurring in the future. One element of the action plan was for all staff who administered medication to undertake a medication competency assessment. The date set for completion of this part of the action plan was 25/8/2016. However, at the time of our inspection there were two members of staff whose competency assessment was still outstanding. This meant the registered manager had not ensured that the action plan had been fully completed in order to minimise future medication errors.

In addition to the concerns raised elsewhere in this report about infection control, poor training records and medicines management the above examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home and their relatives had been given the opportunity to comment on the service through a survey, held in April 2015. This covered areas such as the standard of accommodation, behaviour of staff and communication. The home had received 17 responses from the 41 questionnaires they sent out and overall the comments were very positive. There had not been a survey in 2016, however several 'relatives meetings' had been held, where people could make suggestions about improvements or raise any concerns they had about the running of the home.

We saw evidence that there were staff meetings every few months and where staff was unable to attend they were given the opportunity to read the meeting minutes, which were displayed on the staff notice board.

Accidents and incidents were recorded and investigated. The area manager was in the process of implementing a more thorough accident and falls analysis system.

The registered manager told us that she had a good relationship with the home owners and prior to the employment of the area manager they visited twice weekly to check on the day-to-day running of the home. She commented "They always ask do you need anything''. She told us she could not remember a time when she had asked for something for the home and they had refused her request. She did not receive any formal supervision, although this was going to be carried out in the future by the area manager. She attended 'partnership' meetings, along with the managers of other residential homes in Oldham and told us she ''feels supported''.

Before our inspection we checked with the local authority safeguarding team and Healthwatch Oldham and they informed us that they did not have any concerns about Royley House. The registered manager was

aware of when notifications had to be sent to the CQC and had notified us of required incidents.