Healthmade Limited

Royal Court Care Home

Inspection report

22 Royal Court
Hoyland
Barnsley
S74 9RP
Tel: 01226741986

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Ratings

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

Overall summary

This inspection took place on 12 January 2015 and was unannounced. We last inspected this service in September 2013 where we found that the service was not meeting the requirements of the regulation for supporting staff. This was because staff did not receive regular supervisions and appraisals and there was no system to monitor staff training needs.

Royal Court Care Home is registered to provide care, accommodation and personal care for up to 40 older people in Hoyland, Barnsley. There were 28 people living there at the time of our inspection.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider was not meeting the requirements of the regulation to ensure medicines were managed in a safe way. There was no guidance in place to ensure people received prn (as needed) medicines in a safe way. Medicines were not managed and handled in accordance

Summary of findings

with recognised guidelines and the service's own policy. There was a lack of information about people's medicines and support required in relation to these in their care records.

The provider did not ensure that people consented to their care and treatment in line with relevant legislation. There was a lack of understanding around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005. It could not be demonstrated that decisions were always made in people's best interests and that people were not being deprived of their liberty with appropriate authorisation.

The requirements relating to supporting staff were still not being met. Staff did not receive regular supervisions and appraisals which meant there were limited opportunities available for staff to develop in their roles. There was a lack of an effective system to monitor and identify staff training needs.

Risk assessments were not always in place for people and not frequently updated where these were in place. Care records were not reviewed at regular intervals and one person had conflicting information in place regarding how they were to be supported. There was no information available about how people should be supported in the event of an emergency. One staff member told us they would have to use their initiative. The lack of clear information about what support people needed meant there was a risk they may receive inappropriate and unsafe care. This meant the requirement relating to the care and welfare of people using services was not being met.

There was no audit system in place to monitor the quality or effectiveness of the service. Incidents at the service were not routinely monitored to identify trends and reduce risk of recurrence. We found occasions where some incidents should have been notified to the care quality commission and had not been. The service did not operate in accordance with many of the policies set out and records were lacking in information. Team meetings did not take place regularly to make sure important information was shared.

All of the people living at Royal Court and relatives we spoke with were positive about the care they received and the staff who supported them. Our observations showed that staff interaction was predominantly caring. We saw that people were offered choice about what they wanted to do and staff explained to people what they were doing whilst providing support. People at the service were supported to access healthcare services and received assistance with nutrition where required. There was evidence of involvement with health and community professionals.

There was no activities co-ordinator employed at the service, although we saw and were told about various activities that took place. We also observed some periods where there was a lack of stimulation available for people. Some relatives told us of activities they participated in on a regular basis. No formal relatives or residents meetings took place to share information and obtain people's views. All of the people we spoke with told us they would feel comfortable that any complaints would be dealt with. There were no complaints at the time of our inspection.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to five regulations 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were put at risk of unsafe treatment because medicines were not managed in a safe way. Individual risk assessments were not always in place to help minimise potential risks to people. There was no information about what support people required in the event of an emergency. People spoken with said they felt safe.

There was no formal way to assess whether staffing levels were appropriate. Some people living at Royal Court and staff felt staff did not have enough time to support people

An effective recruitment process was in place so that people were assessed as being suitable to work at the service. Staff knew how to identify and report abuse and had received training in safeguarding so they were aware of what steps to take to protect people.

Is the service effective?

Inadequate

The service was not effective. No assessments had been undertaken in accordance with the Mental Capacity Act 2005 (MCA 2005) to establish whether people were being deprived of their liberty. Decisions were not always being made in line with the MCA 2005 and staff knowledge of the act varied.

Staff did not receive regular supervision or appraisals to ensure staff had sufficient support in their roles.

People were provided with choice at meal times and supported and encouraged with their nutritional needs. People were supported to access healthcare professionals and to maintain good health.

Is the service caring?

Requires improvement

Some areas of the service were not caring. Observations showed that staff were mainly kind and caring in their interactions with people. However, we observed some exchanges which demonstrated a lack of respect for people.

Staff were able to describe people's preferences and offered choice to people whilst providing support.

People and relatives were complimentary about the care they or their family member received and about the staff who supported them.

Is the service responsive?

Requires improvement

The service was not responsive. People's care records did not always reflect their care needs and what support they required. Care plans were not reviewed regularly to identify and implement any changes in a timely manner.

Summary of findings

Although some relatives regularly attended the service, no formal feedback was sought from people using the service or their relatives. There was a complaints procedure in place and all people we spoke with were confident that complaints were dealt with appropriately.

There was no activities co-ordinator employed at the service, although we saw and were told about various activities that took place. We also observed some periods where there was a lack of stimulation available for people

Is the service well-led?

Inadequate

The service was not well led. There was no audit system in place to monitor the quality or effectiveness of the service and make improvements.

Incidents that occurred were not routinely monitored to look for trends, recurring themes and actions to reduce risks. We found records of notifiable incidents that had not been reported to the care quality commission as required.

The service did not operate in accordance with many of the policies in place and records were lacking in information. Team meetings did not take place regularly. No surveys were undertaken with people, staff and stakeholders who used, or were involved with, the service as a means to improve how it ran.

People and staff spoke positively about the registered manager and staff team.

Royal Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 12 January 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted commissioners of the service, the local authority safeguarding team, Healthwatch and a community professional to ask for any relevant information they could provide about Royal Court.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included both formal and informal observation throughout our inspection. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with ten people, and four relatives of people, who lived at the home. We spoke with the registered manager, two senior care workers, two care workers and the cook. We reviewed the care records of four people and a range of other documents, including medication records, staff recruitment files and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with told us that they felt safe living at the service. Comments from people included, "I feel very safe" and "A1, safe as houses." One person said "I did a little bit of homework before I came here and if I saw any malpractice at all I would certainly say something." Another person told us, "I'm not even scared at night time, because they [staff] come in and see that you are alright you know. They just peep in the door quietly to make sure you're ok." Relatives we spoke with were equally satisfied with regards to the safety of their family member and expressed no concerns.

We looked at how the service managed medicines and found areas of unsafe practice. The medication policy at the service stated that people were able to self-medicate if they wished to dependent on their ability to manage and maintain this in a safe way. We saw that one person was prescribed with an inhaler which they self-administered. No risk assessment had been undertaken relating to the person's ability to manage their inhaler, nor was the person's competence to self-administer subject to regular review. When we asked a staff member how this was monitored, they were unable to provide information that this took place. From speaking with the person we did not have any noticeable concerns in relation to their ability to manage this. However, the lack of assessing this meant there was a risk people were not being suitably protected with regards to safe usage of medicines.

Another person had a medicine prescribed to be taken four times a day. We looked at the medication administration record (MAR) charts for the previous month. These showed the person routinely refused this medicine two out of the four times a day it was offered. On these occasions, staff had documented a code which they used to refer to medicine that was offered as prn (as required) and the person had not taken as it was not needed. No details regarding why the person had not needed the medicine had been documented. When we asked the staff member why this was being offered and recorded as a prn medicine as opposed to medicine that was scheduled to be taken regularly they did not know. The staff member told us the person regularly refused to take this medicine at certain times. We asked what had been done about this, such as consulting the person's GP to request advice and/or a review but were told nothing had taken place.

In the care records checked we found a lack of information about the person's needs in respect of their medication, such as what support and level of assistance they may require and what they took any medicines for. There were no protocols in place for where people took 'as needed' (prn) medicines so that staff would know in what circumstances to offer and administer these medicines. One staff member told us they knew how and when people needed medication due to their familiarity with the person. However, they went on to tell us, "I sometimes forget myself if I've been off." The lack of clear guidelines meant there was a risk of medicines being administered in a way other than intended by a doctor. The policy at the service did not provide any guidance for the use of prn medicines.

Care home providers should ensure that all staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. Although staff who administered medicines told us they had received training, this did not take place yearly and it was not clear from the records available who had received training and when. In addition, we found that one staff member was responsible for administering medicines but had not yet undertaken formal training. A senior care worker and the registered manager said this staff member worked with experienced care workers and told us, "There are only a couple of people who need medication." We informed the registered manager that medicines should not be administered by untrained staff. Furthermore, the service's own policy stated that the person in charge of administration of drugs had to be 'trained to appropriate levels' although there was no clarification of what these levels were. As such, medication administration was not taking place in accordance with published guidance and the service's own procedures.

Staff completed no audits or checks of medicines. They told us that the supplying pharmacist undertook external audits every several months which they relied upon. Therefore there was no internal system in place for staff to check that medicines were managed, stored and administered in a safe way and to identify any errors or gaps in a prompt manner so these could be rectified and actions taken to prevent potential recurrence. The lack of monitoring did not safeguard people from unsafe management and usage of medicines. Our findings evidenced a breach of Regulation 13 of the Health and

Inadequate

Is the service safe?

Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 'fire safety' policy and 'emergency and crises' policy both referred to 'arrangements for evacuation of people' being in place. We saw that one fire exit was unsuitable as a means of escape in an emergency. We observed that there was no ramp in place, an uneven surface and bricks and bins were located in places which would cause an obstruction. Staff told us they had regular fire drills. However, they were unable to tell us of any guidance in place about what support people needed in an emergency. One care worker told us they had to "use my own initiative" to know how people would need to be supported. In care records we saw there were no personal evacuation plans in place to provide information about what support each person required. This meant there was insufficient information available so that procedures could be followed to support people appropriately in an emergency situation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training in safeguarding and were able to describe different types of abuse and steps they would take in order to protect people. We saw that safeguarding incidents had been followed up and referred to the local authority.

There were differing views between people we spoke with about whether they felt there were enough staff. One person said, "Yes there are plenty of staff I think. I am pretty much self-managing so it does not worry me too much, but yes, overall I think there are." However, other people commented, "They're never still, always busy, they've a lot on" and "They've been especially busy lately. Seems to be a lot more people in." Another person told us, "I think the staff are under pressure to get on with things which sometimes means they don't have time for more than the basics."

We saw that staff were mostly able to respond to people's requests. However, on one occasion a person who was not independently mobile asked us for assistance as there were no staff present. We had to suggest to a staff member who was assisting us at the time that they respond to the person after a call button was pressed but no staff were forthcoming.

We asked staff whether they felt they were able to meet people's needs with the staffing levels in place. One staff member said they were frustrated that they could not meet all people's needs at the same time. Another felt that cover was sometimes short during the day time. The registered manager told us there were no current vacancies at the service and said she was always on call in case of emergencies. There was no formal tool in place to work out staffing levels and to ensure the levels were suited to the needs of the people at the service. As such, improvements were required to ensure a robust system was in place to maintain suitable staffing.

Most people and relatives were happy with the cleanliness of the communal rooms and bedrooms. One relative said, "It hasn't changed much in the last few years and could do with some updating and refurbishment." They said they had asked management about this and had been told they were on with this. However, the relative went on to say "Nothing seems to come of it and although we visit regularly it always seems to be at the same point every time we come." During a walk round of the premises, we saw some areas in need of attention. In the laundry area we saw dirty sills and cobwebs in corners indicating a lack of cleaning. Some carpets, cushions and fabrics were heavily worn and stained and we saw damp in some places on the ceiling. The registered manager said there were no current refurbishment plans in place and areas for attention were rectified on an 'as and when' basis. There was no infection control lead in place and no audits were done to ensure the premises were safe and suitable. Improvements were required to ensure that the maintenance of the premises and cleanliness were maintained to a suitable level.

We looked at the recruitment files of three members of care staff and confirmed that each hadrelevant documentation in place. We saw that previous employment references and a satisfactory DBS (Disclosure and Barring Service) check had been obtained prior to the staff member being able to commence employment. The Disclosure and Barring Service helps employers make safer recruitment decisions. This demonstrated that processes were in place to ensure that staff were assessed as being suitable to work at the service.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions.

The registered manager confirmed that no DoLS authorisations were in place and no applications had been made, A supreme court judgement in March 2014 had defined an 'acid test' to ascertain whether people lacking capacity were being deprived of their liberty. This test consisted of whether a person was subject to continuous supervision and control, and whether they were free to leave. We noted that the main door to the home was kept locked. Although one person regularly left the home alone unattended, the registered manager said that there were some people whom she believed lacked capacity that would not be free to leave for their own safety. This meant these people should have been considered for a DoLS authorisation to ensure that any restrictions were in line with MCA safeguards.

We saw on a training matrix that only two out of 23 care staff had undertaken formal training in the MCA 2005 in October 2014. One staff member we spoke with was aware of MCA and DoLS legislation, however two others were unable to describe the MCA and how the Act applied to their role and practice. For example, one staff member told us about a person who took one of their medicines covertly by having it administered in their food. They told us this had been agreed with the person's doctor as it was important they took the medicine to manage a serious health condition. The staff member told us they did not believe the person had capacity to understand the necessity for their medicine, which was why the decision had been made to take this covertly. We asked whether a capacity assessment and a best interests discussion had taken place for this decision, in accordance with the MCA. The staff member told us these had not taken place and there was no record in the person's file to show where this decision had been made. Therefore it could not be evidenced that this method of administering medicines was in the best interests of the person.

Our findings demonstrated that the registered manager and staff were not knowledgeable about where people may be being deprived of their liberty. The MCA was not always being adhered to which meant there was a risk of decisions being made that may not be in the best interests of the individual where they lacked capacity. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection also highlighted concerns with regards to the lack of a suitable system in place to monitor staff training needs. We looked at the service's statement of purpose which contained the following comments: 'Royal Court has an ongoing comprehensive training programme' and 'All staff have individual training plans with their training needs being identified through observation, supervisions and staff meetings.' We requested a copy of the service's training policy and supervision policy, and were informed there were no policies in place for either of these areas. Nor were there any individual training plans in place for staff. The training matrix we saw showed that all except two new staff had received training in safeguarding, moving and handling, fire safety and health and safety. One staff member told us they thought the training they had was adequate. Another staff member told us they would like more training. They gave examples of training in certain areas that would be beneficial such as dementia and record keeping.

Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. At our last inspection we identified that staff did not receive regular supervisions or annual appraisals. Following this, the registered manager informed us that she would implement actions to address these shortfalls. At this inspection, we asked staff whether they had received supervisions and two told us they had received one in October 2014. Another staff member, who had commenced employment four months earlier, had not yet had one. None of the staff were able to tell us when their next supervision was due or the frequency of these. The registered manager provided a matrix which showed 13

Is the service effective?

staff members out of 25 had received one supervision since June 2014. None had yet received an annual appraisal which showed that the issues identified at our last inspection had still not been addressed.

Our findings demonstrated a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments about the food were positive and people said they had a choice of meals. One person told us, "You can have anything you want for breakfast, cereals, porridge, toast or egg and bacon." For the rest of the day, people said they had meat and vegetables for dinner and then soup and sandwiches for tea. Other comments included, "There is a choice of [sandwich] fillings and some lovely cake," "I like big portions and I always get them" and "They're very obliging." One person told us, "Some people are on soft diets and they always make sure you can eat the food." They went on to say that following a health issue they had in the past, they had required food to be prepared in a certain manner and this was always undertaken which meant they were able to eat their meals. One relative told us "My [family member] has certainly put on weight in here." Another relative visited the home each day to support their family member to eat breakfast. The person was unable to eat independently and this helped them to receive suitable nutrition. This demonstrated that the service was able to accommodate the needs and preferences of people with regards to their nutritional requirements.

We observed lunchtime at the service. The majority of people ate in the dining room and the food looked appetising with people enjoying their meals. Where people needed support to eat their meals, staff sat with them at a table to provide assistance. We noted that although there was a menu board available on display in the room this was not filled in. The cook said the menu board had been used in the past but was no longer in use. One person said, "There used to be a menu, we would like that" as they did not know what was dinner each day. We fed this back to the registered manager who told us the menu board would be reinstated so that people would know what was on offer for their meals.

The cook was knowledgeable about people preferences and told us if anyone had any certain requirements or allergies, staff would inform him of these and he would record details. The cook told us they could accommodate people's needs and he had flexibility to meet people's choices.

Staff told us that refreshments were usually served mid-morning and afternoon. On the day of our inspection we saw people were offered the morning refreshments approximately ten minutes before they had their lunch. We heard one person acknowledge this was later than normal. We saw no refreshments available in communal areas but people told us they could ask for and receive refreshments when they wanted.

People had access to healthcare professionals to help promote good health and maintain their wellbeing. The registered manager told us that where people had to attend the hospital, a member of staff would attend where a relative could not accompany the person. People and their relatives told us that a doctor was sent for where required. One person required the assistance of a dentist due to a minor accident they had the previous day. The person's friend at the home told us, "It [the accident] only happened yesterday and they've already called the dentist up who's coming out today." A relative we spoke with said of their family member who had some health problems, "They've got the district nurse coming in every other day or so to see to them." A chiropodist attended the home on the day of our inspection. Relatives told us that staff kept them updated with any changes to their family member's health and said they would be contacted immediately. Care records we looked at showed involvement of other healthcare professionals such as district nurses and specialist services such as the memory team. This showed that staff worked in a holistic way with other professionals to support people with their health needs.

Requires improvement

Is the service caring?

Our findings

Everyone living at the service praised the caring attitude of staff. Comments included, "They really care for us and help us in every way they can", "Definitely caring, you couldn't beat them," "Yes very, very caring" and "Brilliant' 'they are fantastic." One person said, "They care here, towards the person, they come first and not material things."

All relatives and visitors we spoke with were equally as positive about the care their family members and friends received. One comment from a visitor we spoke with was, "The staff are without doubt, very kind and caring." Another stated, "The staff are wonderful. Last week they had a birthday party for [my family member] and all the family came along." A district nurse who provided feedback about the home said they found the staff to be caring and responsive to people's needs.

Many people living at the home and staff who worked there were from the same local community. There were some things they shared in common, for example knowing the same people. This meant staff were able to engage with some people on a familiar level and were knowledgeable about their backgrounds. Staff called people by their preferred name in interactions with them and explained what they were doing whilst providing care and support.

People were offered choices such as what they wanted to eat and drink, when they wanted to get up and retire to bed and we heard good natured banter and humorous exchanges. For example, one person told us about an alcoholic drink they liked to have and shortly afterwards a care worker asked them if they wanted "a little tipple of their favourite drink later." The majority of exchanges we saw showed that staff were knowledgeable about people's likes and dislikes.

We looked at four people's care records. We found there was a lack of information about people, such as their background, families, likes and dislikes. One care plan contained a document entitled 'a little bit about me.' However this was not fully completed or comprehensive. This meant there was limited information about people that would help and encourage positive relationships to develop for new staff or new people using the service.

Although we saw some occasions of staff interacting with people when they were not providing care needs, they did not appear to maximise opportunities to interact on a personal level. For example, after lunch when everyone was sat in the lounge, the staff assembled together in a different room.

Most observations showed that staff treated people with kindness and compassion. People told us the staff were always appropriate in what they said and did when helping with personal care. One person told us, "It took me ages to get used to people seeing me without my clothes on, but it's ok now." They said their privacy was respected. We observed people looked clean and smart. One person told us, "I like to look nice, and although these clothes were not dear, they are good quality." The person went on to praise the laundry and said, "They always iron everything so nicely and always look after your things."

However, we observed some exchanges that did not demonstrate a caring or respectful approach. For example, in the lounge we heard one staff member say to a person audibly and in the presence of other people and relatives, "Do you want me to clean that muck out of your nails?" Although the staff member was well meaning, the situation in which it was said and the lack of discretion did not afford the person privacy and respect for personal care they may need.

We noted that some terminology used in daily records was subjective which meant it could give a misleading impression of the person. For example in one person's daily notes we saw reference to a person 'being in a stroppy mood all morning' and being 'stubborn'. We fed this back to the registered manager to look at ways of ensuring staff were respectful of people and how they presented.

Requires improvement

Is the service responsive?

Our findings

We looked at the care records of a person who had been admitted to the home a month prior to this inspection. No care plans had been completed for this person. In the person's file we saw two pre-admission assessments which contained differing information. For example, one pre admission assessment in the section for mobility stated 'no aid to stand, on occasion needs wheelchair for all mobility' whereas the other assessment in the same section stated 'no wheelchair needed.' For sections in bathing and dressing, one assessment stated two care workers were required to provide assistance whereas the other said one care worker was required. There was further conflicting information which meant it was not possible to establish what support needs the person had and how this was to be provided. Furthermore, we noted in the daily records for this person that they sometimes displayed behaviour that could challenge. References were made to the person refusing assistance on several occasions and becoming 'aggressive' with staff. There was no information in place about how staff were to manage this behaviour for the safety of the person themselves, staff and other people using the service.

A senior care worker who also undertook administration duties told us they were responsible for reviewing all care plans. They told us, "They're not all up to date. I'm working my way through them." They said care plans should be reviewed monthly but acknowledged some were longer than this. The care records we looked at had not been updated at regular intervals, some for significant periods of time. For example, one person's care plan for their diet and nutrition was dated 23 April 2014. The person had a MUST (Malnutrition Universal Screening Tool) score of 16 which was 'probable risk' with an instruction to review the care plan monthly. This had not taken place which meant actions as set out in the care plan were not being monitored and followed up to ensure the person was receiving the support and care identified to meet their needs.

We saw the same person also had a high waterlow score recorded in April 2014 which placed them in a high risk category. The waterlow tool gives an estimated risk for the development of a pressure sore in a person. The guidance provided on the risk assessment for this category stated 'Record score and actions taken in care plan every 2 weeks'. Nothing was documented since 24 April 2014 to show how this had been followed up. We also found that this person had had involvement from district nurses for pressure areas several times since this assessment was completed.

Another person who recorded a high score for falls on their risk assessment did not have any care plan in place for their mobility despite the assessment stating that details of how the person was to be supported should be recorded.

Our findings demonstrated that proper steps had not been taken into the assessment, planning and delivery of care to ensure people's needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The lack of accurate, updated care plans and records in respect of people's needs further evidenced a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not employ an activities coordinator. Throughout the day we saw some people talked amongst themselves, some people spent time with relatives and some spent time in their own rooms. One person who we spoke with in their room told us, "I'm remote, I like it here in my room and want to spend time here. I go to the dining room for meals." In the morning, a care worker was offering to paint people's nails and several people took up this offer. One person we spoke with told us they liked to keep busy and asked the registered manager if they could help out with tasks which she had agreed to. They told us they helped to set tables and dry the cutlery and said, "I helped to trim up the Christmas trees too. There were six of them, they looked lovely." People had access to a hairdresser and one person said "If you don't like the one who comes in here, you can have your own and they can come in and do your hair." One person still drove and had their own car available to go out whenever they wished. The person used a motorised scooter within the home and proudly showed us their room including a small bar they had set up.

We observed that in the afternoon there was a lack of stimulation available for some people. We saw one person sat in the same place alone for most of the afternoon with

Requires improvement

Is the service responsive?

little interaction from anyone. One visitor told us, "Meaningful activities are in short supply and people are mainly left sitting in the lounge with TV or magazines to read."

A person living at the service had established a 'residents and relatives association' and along with some visitors had arranged a number of activities such as slide shows and sing-alongs.

A relative who had been to one of these meetings said that staff did not seem to have been involved in this. Visitors told us that meetings were advertised by a notice on the door to the home about when they were going to occur and that these not usually very well attended. From discussions with people, relatives and the registered manager, these meetings were predominantly social events for people at the service. Although the registered manager stated that she had a good relationship with relatives and an open door policy, there was no other formal arrangement for relatives and representatives to be involved with influencing the service.

People we spoke with had no complaints to make about the service. Two people said, "Oh no, love, there's nothing to complain about here" and "I don't think anyone can complain here." When we asked what they would do if they wanted to complain, they told us "We would tell [the manager]." Another person said, "Any complaints get dealt with quickly, it soon gets sorted."

Relatives and visitors, whilst they had no complaints, said they would tell a staff member or the registered manager if they had any concerns. A copy of the complaint's procedure was displayed in the entrance area of the home with guidance on how to complain, expected timelines and addresses for escalation of any complaints. The registered manager informed us there had been no complaints made at the service. We saw a number of compliments and thank you cards on display throughout the service.

Inadequate

Is the service well-led?

Our findings

Everyone we spoke with, except one person, said they knew who the registered manager was and were able to name her. People said she was always available in the home and they saw a lot of her. Comments about the registered manager included, "She is wonderful," "If you need anything you only have to ask her and she will do it." Another person told us, "We've got a good manager [name] always comes and says bye to us all each time she leaves." All people spoke highly of her and one person told us the registered manager always had an open door policy for access.

The culture of the home presented as staff interacting openly with each other and with the people living there. The registered manager told us she placed strong emphasis on the care, and the staff team and told us, "I want people here to feel they're at home, not in a home."

The service had a policy in place titled 'annual development plan for quality assurance' which provided details about how the quality of the service would be monitored. When we spoke with the registered manager, it was evident that this policy was not being adhered to. For example the policy said that quarterly audits would be carried out in the areas of catering, housekeeping, caring and administration. It went on to say that where non-compliance in these areas was identified, an action plan would be implemented. The registered manager informed us that none of these audits had been undertaken and therefore there were no resulting action plans. We asked whether any external or provider monitoring audits had been undertaken and she confirmed that none had. This meant that the service's own policies were not adhered to and there was no system in place to monitor the quality and effectiveness of the service.

The annual development policy also stated that quality assurance surveys would be made available and minutes from monthly residents/relatives meetings would be circulated by the manager. The registered manager said there were previously questionnaires on display for people which she reviewed periodically but these were no longer on display. We looked at completed ones she provided at our request. These consisted of ten questionnaires in total and although the comments were positive, they were not dated except one which was dated 2007. No minutes were available of any prior residents or relatives meetings. No surveys or questionnaires were provided to staff or other stakeholders in order to obtain feedback to influence the service. Therefore people using and involved with the service did not have sufficient opportunity to influence how it ran.

It was evident that some ways of improving the service, suggested by people living at the home, had not been followed up. For example, one person told us, "It would be a good idea for a notice on the wall telling us the day and date so we can see it as sometimes you get confused." We fed this back to the registered manager who told us this had been mentioned before but they could not think of the best place to put this or where to source an appropriate one. We suggested they ask people their preferences and use the information in order to provide the most appropriate outcome.

The manager told us informal team discussions took place on a daily basis and staff were kept updated about information they needed to know by way of these. She stated that formal team meetings did not take place often and the last minutes available were from meetings that took place in March 2014 [the same meeting replicated three times for different staff groups.] These covered areas such as safeguarding, staff conduct and records. When we asked staff about team meetings they could not recall how often team meetings took place, and some could not recall these occurring at all. Although staff told us they felt supported by the registered manager, the lack of formal meetings meant there were limited opportunities to find out information relevant to their roles, share good practice, discuss areas for improvement and any concerns.

Incidents and accidents were recorded in a book that was kept in the treatment room which staff completed. The accident policy in place stated, 'every three months the manager should collate information from accident records and monitor for trend and decide on a plan of action to reduce the risk associated with the trend'. The registered manager confirmed that no monitoring of these had taken place and no action plan had been produced. We reviewed the accidents and incidents contained in these books for 2014 and 2015. We saw that actions had been taken where people had individual incidents or accidents. The lack of any holistic monitoring meant that possible wide spread themes at service level were not being explored with a view to reducing potential risks.

Inadequate

Is the service well-led?

We also noted that some incidents fulfilled the criteria of statutory notifications and therefore should have been referred to the care quality commission in line with the Health and Social Care Act 2008. For example we noted that two people had sustained fractures from falls. These are notifiable as serious injuries, but no notifications had been made. We informed the registered manager that statutory notifications must be made in all cases where incidents or circumstances met the criteria outlined in the Health and Social Care Act 2008.

We noted that some policies and procedures at the service were out of date. For example, several made reference to agencies no longer in existence such as a predecessor of the care quality commission. The policies had last been reviewed in October 2012 with no date of when these were next due to be reviewed. Prior to this, the date of review for most was 2005. For some areas, there were no policies or guidance in place at all. For example the registered manager informed us that there were no policies for staff supervision, appraisals or training. These were areas identified during our last inspection where the regulation was not being met. This meant that despite finding concerns regarding supporting staff , there had been a lack of action to suitably address this in order to improve the service.

Whilst speaking with the registered manager and staff, it became clear that many tasks were the responsibility of one senior staff member. The registered manager acknowledged this and told us this was in part due to her own role as a director of the company, she was often engaged in other tasks such as accounts. This staff member in question compiled the rotas, was responsible for review of care plans, responsible for booking in medication in addition to undertaking shifts as a senior care worker. This was the staff member who told us they had not had time to complete frequent care plan reviews. This also demonstrated that roles and responsibilities were not implemented in a way to ensure the service ran effectively.

Our findings demonstrated that effective systems were not in place to assess and monitor the quality service and to identify and manage risks. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection we found significant shortfalls relating to records and documentation. The registered manager told us that the biggest challenge she found to the service was paperwork and records that were required to be completed. Care plans we looked at were not current and lacking in information. There was a lack of some records in entirety, for example audits and quality assurance. There were no policies and guidance for some areas of the service. For example, there was no information about supervisions and appraisals and the frequency for these and a lack of detailed guidance about how medicines should be managed. This lack of proper information demonstrated a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Assessment, planning and delivery of care did not always ensure people's care and treatment was appropriate, met their needs and reflected their preferences.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Appropriate arrangements were not in place to ensure people were protected from the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected from the risks of unsafe care as there were no systems in place to effectively monitor the quality of the service.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Suitable arrangements were not in place to ensure staff received appropriate professional development, supervision and appraisal.

The enforcement action we took:
Warning notice