Royal Bay Care Homes Ltd

Royal Bay Nursing Home

Inspection report

86 Barrack Lane
Aldwick
Bognor Regis
West Sussex
PO21 4DG

Tel: 01243267755
Website: www.royalbay.co.uk

Date of inspection visit:
07 February 2017

Date of publication:
21 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 29 and 30 November 2016. Breaches of legal requirements were found. After the comprehensive inspection, we issued three Warning Notices and the provider wrote to us to say what they would do to meet legal requirements in relation to breaches of Regulations 12 (safe care and treatment), 14 (meeting nutritional and hydration needs) and 17 (good governance).

We undertook a focused inspection on 7 February 2017 to check that they had followed their plan and to confirm that they now met the requirements of the Warning Notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Royal Bay Nursing Home on our website at www.cqc.org.uk

Royal Bay Nursing Home provides care and accommodation, including nursing care, for up to 35 people. There were 17 people living at the home when we inspected. People living at the service were all aged over 65 years and had needs associated with old age and frailty as well as dementia. The service also provides care for people who are at the end of their lives.

At this inspection we found improvements had been made and that the shortfalls identified in each of the three Warning Notices had been rectified.

The service did not have a registered manager but a new manager was recently appointed and they intended to apply to the Commission for registration. 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 service has been without a registered manager for over a year and at the previous two inspections we identified there was a lack of leadership at the service. The new manager was motivated and committed to improving the service. A new deputy manager had also recently started work at the service; this person was a Registered General Nurse (RGN) and her role involved taking a lead responsibility for nursing care in the service. We found the deputy manager was also motivated to improving the service and had a good knowledge of nursing procedures. The service also had another manager who worked alongside the manager and deputy manager, who referred to themselves as the interim manager.

The provider had taken action to address the shortfalls identified in a Warning notice regarding the safe care and treatment of people. This included the provision of first aid training for staff and taking measures to reduce the risks of injury to people by maintaining equipment correctly. Action had been taken to ensure risks of pressure injuries to people's skin were consistently addressed. Action had also been taken to rectify the concerns we found regarding the safe management of medicines. People and their relatives told us they received safe care and treatment. We spoke to health and social care professionals who identified improvements in how risks were managed.

The provider had taken action to address the shortfalls identified in a Warning Notice regarding meeting people's nutrition and hydration needs. We saw improvements had been made regarding the assessment of people who were at risk of possible malnutrition or dehydration and that referrals were made to relevant health care professionals for advice and support regarding food and fluids. We observed people were supported to eat and drink. People told us they liked the food.

The provider had taken action to ensure there was a system of assessing, monitoring and improving the quality of the services provided which was identified in a Waning Notice as in need of significant improvement. Audits and checks were carried out to identify where improvements were needed. People were able to express their views about the service.
Despite improvements made and compliance with Warning Notices issued, further time and work was required of the provider to ensure compliance with all legal requirements made at the last inspection and to ensure those improvements are sustained over time. We will assess the improvements made and how they will be maintained at our next comprehensive inspection of Royal Bay Nursing Home.

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

We found that action had been taken to improve safety and to comply with the requirements of the Warning Notice for this area.

People received safe care and treatment.

Measures had been taken to ensure staff were trained in emergency procedures.

Medicines were safely managed.

Measures had been taken to ensure equipment was safe for people.

We could not improve the rating for the safe domain from 'inadequate' because to do so required consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

We found that action had been taken to ensure people's nutritional and hydration needs were met where this was identified as a risk. The provider had met the requirements of the Warning Notice for this area.

We could not improve the rating for the effective domain from 'requires improvement' because to do so required consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Inadequate

Action had been taken to improve quality assurance and good governance and the provider had met the requirements of the Warning Notice for this area.

There was a new management team in place who were motivated to improving the quality of service provided to people.

Action had been taken to address areas regulations were not met at the last inspection.

Checks and audits were carried out regarding the safety and quality of services provided.

We could not improve the rating for the well-led domain from 'inadequate' because to do so required consistent good practice over time. We will check this during our next planned comprehensive inspection.

Royal Bay Nursing 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 checked 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 was carried out by one inspector on 7 February 2017 and was unannounced. This inspection was carried out to check on how the provider was making progress to meet three Warning Notices as a result of the last inspection on 29 and 30 November 2016. This involved looking at specific areas in three of the five domains: Safe, Effective and Well-Led.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.
We also considered information sent to us by the provider, including action plans, following the last inspection on 29 and 30 November 2016.

We also used information supplied to us by the local authority safeguarding team and the Clinical Commissioning Group (CCG) who commissioned heath care services with Royal Bay Nursing Home.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with five people and to two relatives. We spoke with the manager, the deputy manager and the interim manager. We also spoke to two members of the provider's regional management team.

We looked at the care records for four people and the medicines administration records (MARs). We reviewed staff training and staff duty rosters. We also looked at records of the quality assurance checks.

Inadequate

Is the service safe?

Our findings

At the inspection of 29 and 30 November 2016 we found the provider was not providing safe care and treatment. This included unsafe procedures for the handling and management of medicines, the unsafe use of equipment, a lack of staff training in first aid and care records not being adequate to show how risks such as the management of pressure areas should be addressed. As a result of these findings we issued a Warning Notice for a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to take action in order to be compliant with this regulation by 6 February 2017. At this inspection we found the provider had taken action to meet the Regulation and comply with the Warning Notice. However, the rating for this domain remains 'inadequate' as we did not review all Key Lines of Enquiry at this inspection and the provider has not yet demonstrated sustained good practice over time. We will check how safety has been ensured and sustained at our next comprehensive inspection and publish what we find, including an updated rating for this domain.

At the inspection of 29 and 30 November 2016 we found staff did not always record their signature in the medicines administration records (MARs) to show if people received their medicines. Stocks of one medicine were found to be out of date. There was a lack of guidance when people needed 'as required' medicines so staff would know when it needed to be given. Clarification had not been sought from a GP regarding the dosage of two medicines. Staff were not aware of the procedures for monitoring the temperature of medicines stored in the fridge. The provider had not taken action regarding people who were confused and had access to food thickeners which placed them at risk if they consumed it. At the inspection of 7 February 2017 we found staff had recorded their signature on the MARs to show if people received their medicines. The stocks of medicines were within date and showed people received their medicines as prescribed. The staff had sought clarification from a GP regarding people's medicines where this was not clear and was highlighted in our last report. Where people had variable doses of medicines this was clearly recorded. A record was maintained of the temperature medicines were stored at in the treatment room and the fridge, although the deputy manager noticed a staff member had not reset the thermometer on the fridge from a previous reading. This was immediately rectified. The provider had taken action regarding the availability of food thickeners to keep people safe.

Since the inspection of 29 and 30 November 2016 additional staff training in the handling of medicines had been provided. A system of medicines audits and checks had been introduced, which included action regarding any errors in the handling of medicines. The deputy manager and manager had a good knowledge of the safe management of medicines. We did identify that one person who received a medicine on an 'as required' basis did not have guidance recorded of the circumstances when this was needed. Records showed the person had been given this medicine but there was no record to show why this was given. The interim manager had a good knowledge of the circumstances when this medicine was needed and acknowledged this needed to be recorded, which she said would be done.

At the inspection of 29 and 30 November 2016 we found there were insufficient numbers of staff trained in first aid at night time and staff did not know how to use the defibrillator. Since then additional training in first aid has been provided to staff which included the use of the defibrillator. We looked at staff duty rosters

and staff training records which showed staff trained in first aid were on duty at night times.

At the inspection of 29 and 30 November 2016 we found people with limited safety awareness had access to a hot water urn with the potential to cause a scald. Since then the provider has taken action to limit access to the hot water urn and had put up a sign to warn of hot water. At the inspection of 29 and 30 November 2016 we found the first aid equipment was not all within its 'use by' date. Since then the provider has replaced the first aid boxes and a monthly audit check of the first aid boxes was carried out.

At the inspection of 29 and 30 November 2016 we found electric convector heaters were supplied in some people's rooms without any risk assessment regarding any risks of burns or fire. At this inspection we found a risk assessment regarding the use of electric convector heaters in people's rooms had been completed. This included guidance that the heaters must be out of reach of people and a sign used to say, 'hot surface.' We observed that this had been done. The inspector raised the fact the risk assessments were not specific to the individual needs of people but were generic. For example, some people may have needs which increased the risk of injury due mobility or confusion whereas other people may be a low risk. The interim manager agreed this needed to be addressed.

At the inspection of 29 and 30 November 2016 we found the assessment, care planning and monitoring of the risk of pressure areas developing was inconsistent and did not ensure staff followed correct procedures. At this inspection we found the risk of pressure areas was assessed and arrangements made for the risks to be mitigated. Care plans gave clear details of when people needed to be repositioned to prevent pressure areas developing. Monitoring charts were used for staff to record when people were repositioned, which reflected the frequency in care plans. Checks were made that pressure relieving air mattresses were set correctly. The risk of pressure areas developing was reviewed on a monthly basis.

Care plans showed other risks to people were assessed such as the risk off falls and the use of bed rails. These risk assessments used a score system to give a rating of the likelihood of risk. People and their relatives said the staff provided safe care. For example, one relative said, "The care is good. It's safe and there are lots of checks." One person also told us they were moved safely.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 29 and 30 November 2016 we found the provider had not ensured people's nutritional and hydration needs were met. As a result of these findings we issued a Warning Notice for a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to take action in order to be compliant with this regulation by 6 February 2017. At this inspection we found the provider had taken action to meet the Regulation and comply with the Warning Notice. However, the rating for this domain remains 'requires improvement' as we did not review all Key Lines of Enquiry at this inspection and the provider has not yet demonstrated sustained good practice over time. We will check how effective care has been established and sustained at our next comprehensive inspection and publish what we find, including an updated rating for this domain..

At the inspection of 29 and 30 November 2016 we found a lack of recorded evidence that referrals and follow up contact with relevant medical services such as the GP or dietician had been made where nutritional assessments indicated people were at risk of malnutrition. Care plans did not always include information about how to increase people's calorie intake where they had lost weight and were at risk of malnutrition. Where food and fluid charts were maintained these did not show people received sufficient food and fluids. Members of the community nursing team and Clinical Commissioning Group reported there was a lack of documentation to show people received sufficient food and fluid and that staff had to be instructed on how to support one person to eat.

At the inspection of 7 February 2017 we looked at four people's care records regarding nutrition and fluids. Malnutrition Universal Screening Tools were used to assess the risk of malnutrition. Where these indicated a risk of malnutrition, referrals were made for advice and support from the dietician services. Care plans included guidance for staff on how to support people to eat. People's weight was monitored and we saw people's weight was stable.

At the inspection of 7 February 2017 we observed people and staff at lunch time. People were supported by staff to eat either by cutting up their food or actually feeding people. There was a choice of food. Where people did not like the meal staff ensured people were provided with a different, meal if they did not like the one given. In the dining room we saw the dessert was served at the same time as the main course and whilst this did not pose a problem for people there was a possibility that people who lived with dementia may be overwhelmed or confused by this. People said they liked the food and that there was a choice available. People spoke positively about the approach of the staff. For example, one person said of a staff member they had just spoken to them about the food, "She's a very attentive lady."

Inadequate

Is the service well-led?

Our findings

At the inspection of 29 and 30 November 2016 we found the provider had not ensured there was an adequate system or processes to assess, monitor and improve the quality of the services provided. This included a lack of an adequate system to assess, monitor, and mitigate risks to the health, safety and welfare of people. As a result of these findings we issued a Warning Notice for a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection of 29 and 30 November 2016 we found the provider had not ensured people's nutritional and hydration needs were met. As a result of these findings we issued a Warning Notice for a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to take action in order to be compliant with this regulation by 6 February 2017. At this inspection we found the provider had taken action to meet the Regulation and comply with the Warning Notice. However, the rating for this domain remains 'requires improvement' as we did not review all Key Lines of Enquiry at this inspection and the provider has not yet demonstrated sustained good practice over time. We will check how effective care has been established and sustained at our next comprehensive inspection and publish what we find, including an updated rating for this domain.

At the inspection of 29 and 30 November 2016 we found a lack of recorded evidence that referrals and follow up contact with relevant medical services such as the GP or dietician had been made where nutritional assessments indicated people were at risk of malnutrition. Care plans did not always include information about how to increase people's calorie intake where they had lost weight and were at risk of malnutrition. Where food and fluid charts were maintained these did not show people received sufficient food and fluids. Members of the community nursing team and Clinical Commissioning Group reported there was a lack of documentation to show people received sufficient food and fluid and that staff had to be instructed on how to support one person to eat.

At the inspection of 7 February 2017 we looked at four people's care records regarding nutrition and fluids. Malnutrition Universal Screening Tools were used to assess the risk of malnutrition. Where these indicated a risk of malnutrition, referrals were made for advice and support from the dietician services. Care plans included guidance for staff on how to support people to eat. People's weight was monitored and we saw people's weight was stable.

At the inspection of 7 February 2017 we observed people and staff at lunch time. People were supported by staff to eat either by cutting up their food or actually feeding people. There was a choice of food. Where people did not like the meal staff ensured people were provided with a different, meal if they did not like the one given. In the dining room we saw the dessert was served at the same time as the main course and whilst this did not pose a problem for people there was a possibility that people who lived with dementia may be overwhelmed or confused by this. People said they liked the food and that there was a choice available. People spoke positively about the approach of the staff. For example, one person said of a staff member they had just spoken to them about the food, "She's a very attentive lady."
At this inspection we found the provider had taken action to meet the Regulation and comply with the Warning Notice. However, the rating for this domain remains 'inadequate' as we did not review all Key Lines

of Enquiry at this inspection and the provider has not yet demonstrated sustained good practice over time. We will check how good leadership, risk management and quality assurance systems have been embedded and sustained at our next comprehensive inspection and publish what we find, including an updated rating for this domain.

At the inspection of 29 and 30 November 2016 we found the provider had failed to ensure the system of audits identified the concerns we found at the inspection, including omissions in care planning for nutrition, the management of pressure areas and end of life care. There was a lack of effective monitoring of the handling of medicines and for dealing with medicines errors. Community nurses raised concerns about how nursing care decisions were made and the service lacked a nurse who was in charge of nursing care.

At the inspection of 7 February 2017 we found systems of audits and checks had been improved. Care plans were monitored on a regular basis. Medicines were also regularly audited and there was a system for dealing with any medicines management errors. The provider had appointed a manager who was a registered nurse and intended to apply for registration with the Commission. A deputy manager had also been appointed and was also a registered nurse. Both these managers were committed to making improvements at the service. The deputy manager was responsible for nursing decisions in the service. The new manager described how the service was setting up a system to ensure NHS patient safety alerts were received so action could be taken to keep people safe.

The interim manager described the system for checking accidents, incidents and the environment to ensure quality and safety of the service. The manager told us that a more structured formal process for this was to be introduced to expand this.

Since the inspection of 29 and 30 November 2016 the provider had responded to any requests for information made by the Commission, which included action plans in response to the findings of the last inspection.

The interim manager showed staff supervision had taken place as required by the last inspection report to monitor staff practice and respond to any training needs.

At the inspection of 29 and 30 November 2016 we found people's personal care records were not secure and confidential. At this inspection we found action had been taken to address this and people's care records were stored securely and confidentially.

The provider had plans to seek the views of people and their representatives about the quality of the service as part of the quality assurance process. At the time of this inspection this was still at the planning stage and the interim manager said this would include further relatives' meetings and satisfaction survey questionnaires for people and their relatives. People told us they were able to raise any issues or concerns with the service's management team and were satisfied with the response.