

Roseberry Care Centres GB Limited

Molescroft Court

Inspection report

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Tel: 01482860367

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The home is registered to provide accommodation and care (not including nursing care) for up to 44 older people, some of whom may be living with dementia. On the day of the inspection there were 26 people living at the home. The home is situated in Beverley, a market town in the East Riding of Yorkshire. There are currently three units within the home; The House, The Annexe and The Haven. Each unit has lounge areas, dining areas, bedrooms and toilets, and The House has communal bathrooms and shower rooms. People living in The Annexe and The Haven have en-suite facilities. Accommodation in The Annexe and The Haven is on the ground floor and accommodation in The House has two floors; there is a passenger lift in The House so people are able to access the first floor if they cannot manage the stairs. There are laundry facilities in The House and The Haven.

The overall rating for this service is 'Requires Improvement'. However, the service has been placed in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive inspections. The 'inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. In this instance the continued breach of regulation has been in the same key question and relates to the safe administration of medication.

This inspection took place on 14 December 2016 and was unannounced. We previously visited the service 6 July 2016. The focused inspection in July was carried out to check on improvements made to the service since the previous comprehensive inspection on 10 and 11 May 2016 when we issued warning notices in respect of three breaches of regulation.

At the inspection in May we found that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medication was not administered safely and recording was unsafe. We issued the registered provider with a warning notice. When we returned to the home in July 2016 we found that they continued to be in breach of this regulation. A Notice of Proposal was issued that added conditions to the registered provider's registration. The conditions required the registered provider to submit information about staff training on the administration of medication and staff competency checks. We received this information within the required timescale. In addition to this, the registered provider was required to send the Care Quality Commission (CQC) copies of monthly medication audits. This condition of the registered provider's registration is still in place.

During this inspection we found that the registered provider continued to be in breach of Regulation 12 relating to the management of medicines. Despite staff training on the administration of medication and staff competency checks being up to date, errors in administration and recording continued to be made. This means that the registered provider remains in Special Measures.

The registered provider told us they were aware that medication errors continued to be made. Because of this, they had made the decision to reduce the number of units to two instead of three, meaning there would be two medication systems in place for staff to manage instead of three, and less medication 'rounds'

each day. In addition to this, they had decided to have one senior care worker on duty whose sole responsibility was to manage and administer medication in the two units. It was anticipated that this would reduce the number of errors being made.

At the inspection in May 2016 we found that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were insufficient numbers of staff employed to ensure people received the care and support they required. We issued the registered provider with a warning notice. When we returned to the home in July 2016 we found that the registered provider had employed additional staff so they were no longer in breach of this regulation.

At the inspection on 14 December 2016 we found that the registered provider was again in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient numbers of staff employed to ensure that people's care needs were met by a consistent group of staff. However, the registered provider had already identified this and had made the decision to reduce the number of units where people were accommodated from three to two. They were confident this would result in there being enough staff employed to ensure people's assessed needs could be met.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have made a requirement in respect of Regulation 18: Staffing.

At the inspection in May 2016 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of quality monitoring. The registered provider was issued with a requirement. This breach was not reviewed at the inspection in July 2016.

At the inspection on 14 December 2016 we found that, although some recording had improved, quality audits had not taken place consistently and the medication audits identified that errors in the management and recording of medication continued to take place. This is a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in July 2016 we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of induction training for staff. We issued the registered provider with a requirement. The registered provider submitted an action plan on 5 September 2016 that informed us of the action they would take to become compliant with this regulation. At the inspection on 14 December 2016 we found that induction training had improved and that the registered provider was no longer in breach of this regulation.

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with CQC. A registered manager is a person who has registered with CQC 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. In the absence of a registered manager, the home was being managed by the deputy manager with assistance from two experienced registered managers of other services operated by the same organisation.

The deputy manager was following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people were working at Molescroft Court.

Staff told us that they received appropriate training, including induction training, and this was supported by the records we reviewed. Staff were also happy with the level of supervision they received.

People told us that they felt safe whilst they were living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

The manager and staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us that staff were caring and that their privacy and dignity was respected.

People's nutritional needs had been assessed and people told us they were satisfied with the meals provided. We observed that people's individual food and drink requirements were met.

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 

Some aspects of the service were not safe.

Some people had not received the medication they had been prescribed and we identified errors in the recording of the administration of medication.

Staff had been recruited following the home's policies and procedures. However, there were insufficient numbers of staff employed to ensure people received the level of support they required.

Staff had completed training on safeguarding adults from abuse. People told us they felt safe living at the home.

Is the service effective?

Good 

The service was effective.

Staff had received appropriate training, including induction training when they were new in post, to equip them to carry out their roles safely.

The manager and staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met and people told us they were happy with the meals provided at the home.

Is the service caring?

Good 

The service was caring.

We saw positive interactions between people who lived at the home and staff.

People told us that their privacy and dignity was promoted and that they were encouraged to maintain their level of independence.

Is the service responsive?

Good 

The service was responsive to people's needs.

People's needs had been assessed and care plans had been developed to record how these needs should be met. However, documentation for the recording of positional changes was not always up to date.

Activities were provided and efforts were made to ensure that people were aware of the activities on offer.

People were informed about the home's complaints procedure and told us who they would speak to if they had any concerns.

Is the service well-led?

Some aspects of the service were not well-led.

There was no registered manager in post. In the meantime, the home was being managed by a deputy manager and two experienced registered manager from other homes within the organisation.

Audits were being carried out monitor whether systems were being followed by staff and that people were receiving good care. However, these were not consistent and had not resulted in medication errors being reduced.

There were processes in place to give people the opportunity to give feedback about the service provided by staff at the home.

Requires Improvement 

Molescroft Court

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 registered 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 14 December 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses / used this type of service. The Expert by Experience who assisted with this inspection had experience of supporting people who used health and social care services.

Before this inspection we reviewed the information we held about the home. This included information we had received from the local authority that commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service.

The registered provider was not asked to submit a provider information return (PIR) prior to this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home, two relatives, five members of staff, the deputy manager and a registered manager from another service in the organisation. We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for three new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One person said, "There are always people around. I can pull the call bell if I need someone" and "It is safe and secure. No strangers can come in." We asked staff how they kept people safe and they told us, "There are key codes on doors, we remove hazards and we make sure people's well-being is at the forefront" and "Doors are coded, we check on visitors, we protect people and we use equipment safely." Relatives felt their family members were safe at the home but one relative added, "The room is safe but I feel uncertain with new agency staff."

On the day of the inspection there were six people living in The Annexe, seven people living in The House and 13 people living in The Haven. We were told that the standard staffing levels were two care staff in The Annexe, two care staff in The House and three care staff in The Haven. There were four staff working during the night; one in each unit plus an additional member of staff. There were eight people living at the home who required the assistance of two staff to mobilise. Because of this, the fourth member of staff was based in The Haven. Our checks of the staff rota indicated that these staffing levels had not been consistently maintained, and this was acknowledged by managers. On the day of the inspection agency staff were still being used to cover staff absences. Managers explained that staff shortages were partly due to current disciplinary issues. In addition to this, a new member of staff had been recruited and inducted and then did not remain at the home, and some staff had given very short notice of sickness absence.

The deputy manager told us that most vacant shifts would have been covered by agency staff. However, this had not been recorded on the staff rota so there was a lack of evidence that the home was fully staffed.

People who lived at the home told us there were not enough staff on duty. Comments included, "Not now – they seem short particularly at night – I know because the staff tell me. However, I still attend activities like bingo and trips out", "Just recently [they have been] short staffed. When I ring it can be a ¾ hour wait but not always", "Better than it was a few months ago. They usually respond to call bell in 10 minutes but it can be half an hour or longer at night" and "Not on a night, but the call button is answered pretty quickly."

Relatives told us that they felt more staff were needed. Comments included, "Recent waits for [staff to respond to] the call button have been half an hour", "The call bell was sounding in the lounge and an agency worker was sitting down using their mobile phone. I had to ask them to answer the call button" and "Usually there are three staff on duty but at times they could do with more." One relative told us, "You never know who is going to be in. Repositioning charts say two hourly but sometimes its three to four hours." This relative also showed us their family member's food and fluid chart. This recorded that hourly entries should be made. We saw that there was an entry at 8.30 am and that the next entry was at 11.30 am. We also saw in one person's care plan that they should be checked in their room every two hours. One record we saw indicated the person had not been checked for three and a half hours, although other entries we saw were at two hourly intervals.

This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ancillary staff were employed in addition to care staff. This included cooks, kitchen assistants, a housekeeper, domestic assistants, laundry assistants and a handy person. This meant that care staff were able to concentrate on supporting the people who lived at the home.

The registered provider had taken steps to reduce the reliance on agency staff and to make sure the home was fully staffed. They had decided to use two units instead of three units. Some people had agreed, following consultation, to move to another unit. This meant that the current staff group could be deployed to work in two units rather than three units so that there were sufficient numbers of staff to meet the needs of people who lived at the home. The week following the inspection, we received email confirmation that this had been actioned.

Staff told us that management had recently agreed to pay overtime at 'time and a half' rate. This meant that staff were willing to work overtime and that the home would be able to use less agency staff. This showed that the registered provider had taken action to address the identified concerns in respect of staffing levels in the future.

Following the inspection in July 2016 we imposed a condition on the registered provider's registration that required them to submit information to us about the management of medicines. Initially they were required to submit details of the training each member of staff had received on the administration of medication and evidence that these staff had received a review of their competency. In addition to this, each month the registered provider was required to submit written evidence of their medication audit in all three units. The registered provider complied with these conditions of their registration.

However, we noted that the audits showed that errors in recording continued to be made.

We checked the medication administration record (MARs) for the three units. We saw that there were protocols in place for 'as and when required' medication and that codes were used correctly to record when medication had not been administered. However, there were numerous gaps in recording, particularly in The Haven, where staff had not signed to record whether they had administered people's medicine. In addition to this, the MARs and the sheet to record PRN medication did not always match and the forms to record the application of pain relief patches was not always the same as the corresponding MARs. This meant the records of administration were confusing and inaccurate. This was acknowledged by the deputy manager.

Managers told us that they had consulted with senior staff to discuss why they thought errors continued to be made. Staff said that they frequently had to administer medication in a unit where they did not usually work, due to the shortage of staff who had received appropriate training. They felt that this led to errors being made. The registered provider decided to reduce the number of units where people were accommodated from three to two, and to have a senior staff member on duty whose only responsibility was to manage and administer medication in these two units. The registered provider anticipated that this would ensure the safe management of medication in the future.

The temperature of medication fridges and medication rooms had not been recorded consistently. This could have resulted in medication not being stored at the correct temperature.

This was a continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled drugs (CDs) for all three units were stored in the medication room in The House. CDs are

medicines that have strict legal controls to govern how they are prescribed, stored and administered. We checked the amount of stock held in the CD cabinet and established that it matched the records in the CD book.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Records evidenced that unused medication was disposed of appropriately.

When concerns had been identified in respect of a person's care, risk assessments had been undertaken to record how the risk could be managed and reduced. We saw risk assessments for moving and handling, the risk of falls, the risk of dehydration, weight loss, the use of bed rails and pressure area care.

We reviewed the folder where safeguarding information was stored. It included the local safeguarding board procedures and information about the 'threshold' tool introduced by the local authority. The safeguarding tool had been used to identify whether the issue needed to be managed 'in house' or whether an alert needed to be submitted to the local authority's safeguarding adult's team. This showed that any concerns in respect of safeguarding adults from abuse had been reported to the local authority and the Care Quality Commission as required. Staff were able to describe different types of abuse they might become aware of and the action they would take to make sure people were safe.

We noted that care plans included a record of any accidents or incidents involving the person, that people were closely observed following any accidents or incidents and that these observations were recorded. We checked the folder where accidents and incidents were recorded and noted that appropriate medical advice had been sought for people following any accidents or incidents. However, we did not see any analysis of accidents or incidents that could highlight patterns that were emerging or improvements that needed to be made.

We checked the recruitment records for three new members of staff and found that these had improved. The records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at the home.

Staff were issued with a staff handbook and a job description when they were new in post. This set out the expectations of the organisation.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for portable electrical appliances, the passenger lift, mobility hoists, the fire alarm system, the call bell system, gas safety and the electrical installation.

The handy person carried out in-house checks on the water temperatures, fire safety (including the fire panel, fire extinguishers, fire doors and emergency lighting), the call bell system and window opening restrictors.

We saw that there was a business continuity plan in place that included details of everyone who lived at the home and staff, emergency contact numbers and guidance for staff on how to deal with a variety of emergency situations. In addition to this, there was a personal emergency evacuation plan (PEEP) for each

person who lived at the home, although we noted that some we looked at did not record the assistance people would need to evacuate the premises in an emergency.

We found the home to be clean and hygienic on the day of the inspection. This was confirmed by the people who we spoke with. We saw that domestic staff were carrying out their duties throughout the day of the inspection. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority's Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Is the service effective?

Our findings

At the inspection in July 2016 we were concerned that staff had not undertaken thorough induction training before they commenced work at the home. At this inspection we saw that new staff had completed training before they commenced work. This included training on safeguarding adults from abuse, health and safety, infection control and moving and handling. In addition to this, staff who had been promoted from care worker to senior care worker carried out further induction training to prepare them for this role. This included training on the administration of medication.

We asked people if they thought staff had the right skills and they all told us they felt staff were well trained. One person said, "If they [staff] are new they have someone with them." Comments from relatives included, "Regular staff, yes. Agency staff are just there to fill in. Staff use the hoist and there is always two of them. It seems okay" and "The majority of the regular staff are very good."

We reviewed the home's training record. This recorded the training that was considered to be essential by the home. Topics included fire safety, food hygiene, moving and handling, health and safety, safeguarding vulnerable adults from abuse, the safe use of bedrails, infection control and nutrition / hydration. Other training available to staff included medication (for senior staff only), pressure ulcer prevention, dementia awareness and end of life care. We noted that most staff had now attended the home's essential training.

We asked staff what training they had completed in the last year. They told us that they had attended training on first aid, moving and handling, safeguarding adults from abuse, safe handling of medication, health and safety and fire safety. In addition to this, some staff had achieved a National Vocational Qualification (NVQ) at Level 2 or 3. NVQ's have now been replaced by the Qualifications and Credit Framework (QCF) award; QCF is the national occupational standard for people who work in adult social care.

This meant the registered provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of induction training for staff.

There was a supervision policy in place and a system for recording the frequency of staff supervision. Supervision is a meeting that is held between a staff member and their line manager when the staff member's progress, any concerns and any training needs can be discussed. The supervision system had recently lapsed. However, two long-term staff told us they felt well supported by managers, and one of these staff members said they had attended a supervision meeting during the previous two or three weeks. One new member of staff told us they did not know what supervision meetings were.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw evidence of best interest meetings that had been held to make decisions on behalf of

people who lacked capacity to consent. For example, one person's care plan included the names of people who had been involved in the best interest decision in relation to them having their photograph taken to be included in records at the home.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that care plans included a DoLS checklist that was used to determine whether people were being deprived of their liberty. There was a record of DoLS applications that had been submitted to the local authority, applications that had been authorised and when these were due for renewal.

Although staff training records showed that only three staff had completed training on the MCA, staff who we spoke told us they understood the principles of the MCA and DoLS. They confirmed that physical restraint was not used at the home.

A power of attorney (POA) is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf when they lack the capacity to make decisions for themselves. Care plans included information about a person's POA or Lasting POA when someone was acting as their representative. This included whether they had POA for health and welfare and / or financial affairs. One relative who we spoke with confirmed that they had POA for their family member.

Relatives told us they were involved in making decisions about their family member's health and welfare when this was appropriate. People had care plans in place about their capacity to make decisions and consent, and in addition to this, people had signed consent forms when they were able to do so. We saw consent forms in respect of photographs and the administration of medication. We saw that staff obtained 'implied' consent when they were supporting people throughout the day by checking that people were happy with the care or support being provided. People who lived at the home confirmed this. One person told us, "They [staff] never do anything without asking."

People told us they had choice and control over their care. One person said, "I am in control of my own life" and another told us, "They [staff] don't get away with anything." Staff described to us how they helped people who lived at the home to make day-to-day decisions, such as choosing meals and clothes. Comments from staff included, "We ask about food preferences and what they would like to wear – basic choices, but nice for people", "We give them choices about what to wear. We ask them and guide them. We give a choice of when to get up and when to go to bed" and "We ask people what they want to do, and also ask their family."

Nutritional assessments and risk assessments had been carried out and a member of staff told us how people's nutritional intake was monitored. They said, "We use weight charts and involve dieticians if needed. We also ask people how they are." People were being weighed as part of nutritional screening and, when there were concerns about weight loss or gain, people had food and fluid charts in place. We saw that the amount of fluid the person was drinking had been totalled each day, making it easier for staff to monitor the person's overall fluid intake. Advice had been sought from dieticians and speech and language therapists (SALT) when there were on-going concerns in respect of people's eating and drinking.

People told us they were happy with the meals provided by the home. One person commented, "If I don't like it I can have something else. Fish and chips every Friday is very nice." We saw that people were

encouraged to drink throughout the day.

We observed lunch being served in The Annexe and The Haven. We noted that tables were set with tablecloths, placemats, a table decoration, napkins and cutlery. We observed that those people who needed assistance to eat their meal were supported appropriately by staff. Staff chatted to people to promote mealtime as a social occasion. We saw there was a menu on display, but this was written in small print so was not accessible to some people. The cook told us that care staff asked people each afternoon which of the two choices of meal they would prefer the next day and that other meals were available if people did not want either of the choices on offer. Two people required a 'soft' diet and some foods were fortified by adding cream, butter and cheese to them. This meant that people who ate a small diet continued to have their nutritional needs met. We saw that the meals provided looked hot and appetising and that portion sizes were appropriate.

People told us they had easy access to their GP. One person said, "I have seen one a few times and a district nurse" and another told us, "They would get a GP and I am seeing a district nurse for my legs." We saw that any contact with health care professionals was recorded, including the reason for the contact and the outcome. People's records evidenced that advice that had been sought from health care professionals, such as district nurses, chiropodists, occupational therapists and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. There was a record showing that any equipment needed to assist people to mobilise or prevent pressure sores had been provided.

People had patient passports in place. These are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff.

Bedroom doors were painted a different colour and bathrooms, toilets and other communal areas of the home had clear signs to help people orientate themselves around the home. However, some areas of the home were not easy to access. Rooms in The Annexe had steps up to them and one bedroom had a steep ramp to negotiate. The windows in The Annexe and The Haven were perspex rather than glass; some of them had become opaque and difficult to keep clean, so were difficult to see through. The registered provider acknowledged all of these difficulties and had taken advice on appropriate ways to make improvements to the premises.

Is the service caring?

Our findings

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient in the way they interacted with people. People told us they felt that staff cared about them. Comments included, "If I wanted anything they would get it for me" and "Staff are very kind. If you want anything doing they will do it" Relatives also told us they felt staff genuinely cared about the people who lived at the home. One member of staff told us they felt staff at the home went 'over and above' their caring roles.

Relatives told us that their family members were encouraged to remain as independent as possible. Staff told us that they encouraged independence. One member of staff said, "We don't take away their abilities" and another said, "We encourage people. It's very much 'use it or lose it'."

Some care plans included information about people's preference in respect of being supported by a male or female care worker. One relative told us, "We requested no male carers and this has been followed." People told us that staff respected their privacy and dignity by knocking on doors before entering their room.

Staff described to us how they respected privacy and dignity. They said, "We close toilet doors and when showering keep them covered as much as we can" and "We always close doors and keep them covered with a towel when doing personal care."

We noted that people were well dressed and were wearing appropriate footwear to reduce the risk of trips and falls.

We asked people if staff shared information with them in a way they understood. Comments included, "I talk to them and I understand", "They talk to me any time of the day. They have patience to talk to you", "They talk when they care for me, but it's difficult with agency staff" and "When they are in my room but they are short staffed." Relatives told us that they were happy with the communication between themselves and staff at the home. We saw there was a form in care plans that recorded any contact made with people's relatives. Relatives told us that they were kept informed about events such as GP visits.

Discussion with staff revealed there were people living at the home with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service. The care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. One person told us, "Every Monday I have a lady who gives me Holy Communion" We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

We saw information about advocacy services displayed within the home. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Is the service responsive?

Our findings

People we spoke with were not sure if they had a care plan or if they helped to develop it. We asked people if they felt the care was centred on them and the responses varied. Most people were not certain, but one person said they felt the care was personalised. They said, "You only have to ask and they are there."

The care records we saw included care needs assessments, risk assessments and care plans. Assessments included an overall dependency assessment plus assessments for moving and handling, falls, pressure area care, the control of infection and nutrition. Assessments were scored to identify the person's level of need and any associated risks. Any risks were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk. Care plans covered areas such as eating and drinking, sleep, hearing and eyesight, mobilising, communication, skin care, maintaining a safe environment, personal care, memory, capacity and consent, medication and end of life care.

Some care records included a document called 'This is Me' and others contained a memory diary. These documents included information about the person's family members, childhood, work, hobbies and favourite singer / drink / books / colour and time of year. This gave staff useful information that they could use to get to know the person better and therefore provide more person-centred care. We asked staff how they got to know about people's individual needs and they told us; "Care plans include a lot of information, and we also speak to families", "We talk to clients. I talk to them all and I have the time" and "I read the care plan, we try to make an effort to get to know them."

We saw that care plans were reviewed and updated each month. Formal reviews had been held for some people to discuss whether their care plan remained relevant; some of these had been organised by the local authority and others had been organised by the home. This meant that staff had up to date information about people's care needs.

However, we noted that positional change charts were not always up to date and a relative told us that their family member was not assisted to change position every two hours as required. This was confirmed in some of the records we saw. We discussed this with the registered manager at the end of our inspection and they assured us this would be addressed with staff. We have addressed this in the Well-led section of this report.

Handover meetings took place so that information could be passed from one shift to the next. Staff told us that they were expected to arrive 15 minutes early for their shift so they could handover information to the next shift. They said that some staff were not arriving 15 minutes early so handover meetings were sometimes hurried, meaning a thorough meeting could not always take place.

Relatives told us that there were no restrictions and they were able to visit the home at any time. People who lived at the home told us that their relatives were made welcome. One person said, "They [staff] always make drinks for them." Comments from staff included, "We assist people to phone their relatives and always welcome visitors" and "Family can phone any time and we encourage family to visit at any time."

We spoke with the activities coordinator who told us they worked for six hours a day, Monday to Friday. They said they encouraged people to take part in activities and that they organised bingo, puzzles, nail care, one to one chats and colouring. They also told us they arranged trips out to local pubs and garden centres and for entertainers to come into the home. They added that they were also responsible for accompanying people to health care appointments so that took them away from providing activities. We asked the activities coordinator if they had undertaken any training on providing activities for people who were living with dementia and they told us they had not. However, people told us they were happy with the activities on offer. Comments included, "I like to play bingo and we went to a garden centre recently for a meal", "If there is a singer they [staff] take me in a wheelchair" and "We go singing and I do my own puzzles and we go to the pub."

A member of staff told us, "We have a fantastic activities coordinator. They are good at involving people. We also have visitors from the Church who come in." Another member of staff said, "[People take part in] bingo, puzzles, Christmas decorations and they have trips out." We saw some activities were taking place on the day of the inspection.

People told us they were not kept informed about what was happening in the home. They said they had not attended 'resident' meetings and had not completed a satisfaction survey. However, we saw that surveys had been distributed to people who lived at the home about catering / food provision, housekeeping and activities. The feedback about catering / food provision and housekeeping were mainly positive, but there were mixed responses to the availability and type of activities on offer. On the day of the inspection we received positive feedback about activities, which indicated some action had been taken following the survey being carried out.

We saw that the complaints procedure was displayed in the home. We checked the complaints log and saw that any complaints received had been recorded, including details of any investigation and the outcome.

People told us they understood how to share concerns or complaints with staff. Comments included, "I would tell a carer, but I don't really know, I never have", "I would tell a carer, but I have no complaints" and "I would tell one of the staff or the boss. I have complained about agency staff [because they couldn't understand me]." Relatives also understood how to make a complaint. One relative told us, "I have phoned HQ and it was dealt with" and another one told us, "I would now mention problems to staff or [name of deputy manager]." Staff told us they would try to deal with minor concerns themselves. However, if the concern was more serious they would share this with the deputy manager. They were confident that people's concerns would be listened to and dealt with.

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection there was no registered manager in post. The home was being managed by the deputy manager with assistance from two registered manager of other homes in the organisation.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We saw that various audits had been carried out to monitor the quality of the service provided. These included audits on infection control (although these were incomplete), catering, health and safety, medication and care plans. We noted that the care plan audit had highlighted some shortfalls in recording in care plans. The deputy manager told us that staff had been told about these shortfalls but they had not taken action to bring the care plans up to date. We noted that the audits of accidents and incidents had lapsed. Despite audits being carried out on the management of medication, errors continued to be made. Some positional charts had not been completed consistently. This meant that risks to people were not always being mitigated.

This was a continued breach of Regulation 17 (2) (a)(b) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that most of these were well kept, easily accessible and stored securely. In addition to this, we saw that the quality ratings we had awarded at our previous inspection of the home were clearly displayed.

Staff told us they were aware of the whistle blowing policy at the home, but they all said they had not needed to use it. However, one member of staff added that they were not confident any information shared with managers would remain confidential. At the end of the inspection we told managers that not all staff were confident information shared with them would remain confidential.

We asked people about the management of the home and if they felt able to meet with the deputy manager. Two people told us they did not know who the manager was, but two people were aware. One person said, "The regional manager is [person's name] and the manager is [Name of deputy manager]. I would talk to them." Another person told us, "[Name of deputy manager] – she is nice. She took me to Hull Fair." A relative told us, "My sister [another relative] finds the manager very nice."

Staff told us that they felt well supported by managers. One staff member said, "I think we have had a lot of management support, both regional and from head office" Another member of staff told us, "[Name] is the manager and is lovely, and I get on well with everyone."

A relative told us that communication from staff at the home had improved in the last couple of months. They said that they received emails to update them about any concerns, and that they also received a newsletter. Two relatives told us they had attended relatives meetings. One relative said, "My sister [another relative] always goes. I have gone to some. The only issue is staff continuity" and another told us, "There was a relatives meeting last week. We ask questions – pureed food has improved." This showed that the opinions of family members were listened to.

We saw the minutes of the recent staff meeting (5 December 2016) and saw the topics discussed were staff sickness levels and that staff needed to work as a team to make the required improvements and become compliant with CQC. The most recent senior staff meeting was held in July 2016. These minutes evidenced that concerns about medication errors were discussed and the improvements that needed to be made to medication management, as well as shortfalls in care planning. Three members of staff told us about meetings they had recently attended. They said they were able to ask questions and make suggestions at these meetings.

Surveys had been distributed to people's relatives and friends. Following the inspection, we were sent a copy of the analysis of the collated responses. The survey asked questions about personal care, catering / food, daily life / activities, management and the environment. The feedback showed that most concerns were about the environment and facilities at the home. It was acknowledged by the registered provider that there were some challenges in respect of the environment, such as accommodation being in three separate buildings and steps / ramps to people's bedroom doors.

We asked staff to describe the culture and the atmosphere of the home. One member of staff said, "I feel it is open" and another said, "It is open and good as far as I am concerned." A third member of staff told us that the atmosphere at the home had improved, as there had been less reliance on agency staff and team work had improved. They described the atmosphere as "Friendly and happy." We noted that there was a pleasant atmosphere around the home and that staff seemed happy in their work.

A member of staff said they were confident that any accidents, complaints or safeguarding concerns would be discussed openly and that efforts would be made to reduce the risk of similar incidents occurring again. Another member of staff gave us an example of a person who had a strong sedative at bedtime and they had learned they needed to stay with them until they fell asleep, as this occurred quickly and they needed to ensure the person remained safe.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had quality assurance systems in place but these had not effectively assessed, improved and monitored the quality and safety of the services provided, or mitigated the associated risks. Regulation 17 (2) (a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet people's assessed needs. Regulation 18 (1)