# Lilian Faithfull Homes

# Royal Court

## Inspection report

Royal Court
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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 29 and 30 August 2017 and was unannounced.

This was the service's first inspection under the registered provider who acquired the home on 1 August 2016.

This service is registered to provide care to a maximum of 48 people. The home does not provide nursing care. People's accommodation comprised of flats which could be singularly occupied or shared. Communal areas such as lounges, dining rooms and a spacious conservatory were used on a daily basis by people and for social activities. Additional bathrooms and toilets were provided on each floor. Outside there were areas to sit, which were accessible by wheelchair and the gardens were well tended. One corridor, on one floor, provided accommodation for people who lived with dementia and who benefited from a smaller and more secure environment. People from this area also used the main part of the building and the gardens. They were supported to join in activities in other parts of the home and join others for meals.

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

The inspection was prompted in part by concerns we had received about the quality of service being delivered to people who lived with dementia and by the notification of an incident, following which a person using the service sustained a serious injury. This incident is subject to a separate process and as a result this inspection did not examine the circumstances of that incident. However, the information shared with CQC about the incident indicated potential concerns around the management of risk in relation to people's agitation and associated behaviour. This inspection examined those risks and how they were managed.

The provider was not meeting all necessary regulations. They had not sufficiently assessed people's risks and reviewed the risk management plans they had put in place to ensure these were effective in keeping people safe. Repeated incidents, of a similar nature, had taken place without thorough review, to ensure action would be taken to prevent these from recurring. Necessary learning from these incidents and adjustment to people's support had not always followed. Although incidents which had put people at harm

had been discussed with the local county council's safeguarding team, CQC had not always been appropriately notified about these. As a result the necessary enquires to ensure people were safe had not taken place. The above shortfalls related to risks and incidents involving people who lived with dementia becoming agitated, distressed and disorientated.

Records required in relation to people's care and how the home was managed were not always in place or sufficiently completed. In practice we observed people being supported to make decisions, staff promoting independence and acting in people's best interests when delivering care. However, records did not always demonstrate how decisions had been made for people who lacked the capacity to make decisions about their care independently, so as to ensure their rights were upheld. Records did not always demonstrate that complaints had been sufficiently investigated, acted on and responded to. These shortfalls had not been identified by the provider's quality monitoring and assurance processes. This process, therefore, had not been sufficiently robust and effective enough to ensure improvement in these areas had taken place and best practice applied.

Staff were aware of their responsibilities in relation to preventing potential abuse. Staff had received training and support to be able to meet people's needs. Care plans did not always give staff sufficient guidance on how people's needs were to be met. The potential impact of this and associated risks were lowered because staff knew people well and there were experienced care staff employed. The provider had already identified that changes to people's care plans was needed and this was being addressed. There were enough staff in number to meet people's needs. Staff prioritised people's needs so that when people were distressed, agitated or required immediate support this was provided. Sometimes, there were too many needs for staff to manage alone and the provider was due to review how staffs' work was organised and allocated. More senior care staff were due to work at the home to provide direction and support in this area.

People's medicines were administered safely and securely stored. Medicine errors had been reported to us. In both cases there had been no significant impact on the people involved and action had been taken to prevent these from happening again. People lived in a home which was kept clean and where there were measures in place to prevent the spread of infection.

People were supported to eat and drink and to receive a diet which met their nutritional needs. Our observations showed that people's dining experience needed improvement and actions were subsequently taken to start addressing this. People were supported by health care professionals where there was a need for their involvement. Staff communicated with and worked in conjunction with many different health care specialists to ensure people's health needs were supported and met.

People were cared for by staff who genuinely cared for them and were interested in them as individuals. Comments from people had included staff are "caring and sympathetic" and "fantastic". People told us they felt able to talk to the staff about anything. Relationships between people and staff were observed to be relaxed. Comments placed on a website used by people and relatives in order to review the home included, "The staff are caring and interested in me as a person" and "They always have time for you." Where possible, people's preferences were respected.

Managers in the home and representatives of the provider were committed to doing their best to improve people's quality of life. Our visit, however, identified that the processes needed to achieve this had not always been well managed or monitored. There was however, evidence to show that some monitoring systems had led to actions being taken and improvements being made. Staff felt supported and well communicated with. There were arrangements in place which helped the senior management team and members of the board of trustees remain 'in touch' with the views of people and of their progress.

It was recognised by the provider that the building presented some challenges, in particular, when looking after people who lived with dementia. Some improvements and adaptions had been made to the building and grounds to better accommodate people's diverse needs.

It was evident through our conversations with the registered manager and Director of Care they were motivated to continually improve the service and were keen to take action to ensure good care was provided to people. The provider had already identified a need for care plans to change as they wished to bring these in line with those used in other services managed by them.

You can see what action we told the provider to take at the back of the full version of the report.

Following our visit, we requested the provider forward to us an initial action plan on how they planned to keep people safe and how they planned to address the shortfalls we had fed back to managers during our visit. We will continue to communicate with the provider on their progress with these. We will be following up the provider's improvement actions in a future inspection.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People were not always protected against risks that may affect them personally. Risks had not always been fully identified and assessed. Risk management processes had not always included a review of the actions put into place to lesson risks and therefore ensure these remained sufficient and effective.

There were arrangements in place to protect people from abuse, but senior staff had not always reported incidents appropriately to the CQC. Action was taken after our visit to ensure this did not continue.

There were enough staff in number to meet people's needs. Changes to how staffs' work was organised and how mealtimes were organised have been made to ensure people receive safe and effective support at all times.

The staff recruitment process protected people from those who may not be suitable.

People received the support they needed to take their medicines. Medicines were managed safely and where there had been a medicine error, action had been taken to prevent this from happening again.

Environmental risks were monitored, identified and managed. People lived in a home which was clean and where arrangements were in place to lessen the risk of infection.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff understood the principles of the Mental Capacity Act and people were supported to make decisions about their care. However, people's records, in relation to mental capacity assessments and best interest decisions, needed to improve to

evidence that people and their legal representatives had been provided with the appropriate support to aid their decision making.

People were cared for by staff who received appropriate training and support.

People were supported to eat their food and to have their drinks. People's nutritional risks were identified and managed.

Staff worked with other health care and social care professionals and agencies to support people's health needs.

## Is the service caring?

**Good**

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

Everyone was treated as an individual and their individual needs and capabilities considered and respected. People's rights were upheld and their privacy and dignity maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

People's end of their life wishes and needed for respected and met.

## Is the service responsive?

**Requires Improvement**

The service was not always as responsive as it could be.

Care plans, lacked accurate detail and sometimes sufficient guidance for staff to ensure people's needs were met appropriately. However, the provider had started to make improvements to these.

People had opportunities to socialise and take part in activities of their choice. Links had been made with the local community and people were supported to use these.

There were arrangements in place for people to raise their complaints, although relevant records about these had not always been sufficiently completed to show these had been appropriately investigated and addressed.

## Is the service well-led?

**Requires Improvement**

The service was not as well-led as it could be.

The provider's quality monitoring processes had not always been effective in identifying shortfalls which potentially put people at risk. Some other areas of monitoring had been effective and had resulted in improvements being made to the service.

Managers were approachable and staff spoke highly about how the home was managed and the support they received.

The views of people, their relatives and staff were sought and managers were open to suggestions which could improve the service.

# Royal 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 and 30 August 2017 and was unannounced. The inspection was the service's first inspection under the current provider.

Prior to the inspection we reviewed the information we held about the service from the 1 August 2016 when the current provider started to manage the service. This included a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted to the Care Quality Commission on 9 June 2017. We reviewed statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. We also looked at a website where people and relatives can feedback their view of the service.

The inspection team consisted of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person who cares for an older person and who acts as an advocate for people who use adult social care services.

During our visit we spoke with seven people who lived at Royal Court and one relative to gather their view of the service. We spoke with two senior representatives of the provider, the registered manager, deputy manager, one dementia support worker, seven care staff, one activities co-ordinator, one kitchen assistant, one cook, one domestic, the training and compliance officer and two administrators. We sought the views of commissioners of the service.

We reviewed eight people's care records. We reviewed documentation related to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We also reviewed records relating to the management of the service. We reviewed a selection of audits and additional reports submitted to the provider. We reviewed the minutes of a 'residents and relatives' meeting and of staff meetings.

We requested that a copy of the staff training record and safeguarding policy be forwarded to us which the provider did. The provider forwarded a selection of additional evidence to us after our visit.

Requires Improvement

# Our findings

People who lived with dementia relied on staff to both identify and manage risks relating to their anxiety and associated behaviours. We reviewed how risks, related to people's behaviour, had been assessed and managed to ensure they and others were kept safe. We found staff knew people well could explain the triggers that made people anxious and which led to agitation. One staff member told us ''We know they [people] like everything in place and things to be done in a very specific way. We work hard to stick to their routine as that helps them to relax.'' Throughout our visit we observed staff supporting people by using distraction techniques and providing reassurance. This helped people to become more calm and relaxed. Incident reports indicated for one person that incidents related to their behaviour had decreased. The use of occasional medicine to manage their agitation had also decreased as staff had become more confident in supporting this person's anxiety.

However, we found people were not always being protected from risks associated with their care, because the service had not consistently assessed and reviewed people's risks. We found that although some risk assessments were being undertaken, it was not always clear that actions taken had successfully mitigated or managed risks to people. Some evidence was missing and instructions or guidance for staff was not always available.

We found for example, that detailed behaviour support plans and risk assessments were not always in place for people's behaviour and associated risks to ensure staff always knew what support had been planned for people. One person's care plan did not inform staff of what might trigger their behaviour, strategies to prevent their behaviour from escalating and how to keep them and other's safe if their behaviour was to escalate. There were no other behaviour management plans or risk assessments in place providing this information.

Another person's behaviour care plan had not been reviewed to include information to ensure staff knew what signs would indicate that the person's required their occasional medicines. When this medicine had been administered staff had not always recorded why this had been required so that the registered manager could review whether this medicine had been used appropriately. This person's care plan also did not include all the strategies staff told us they used to reduce this person's anxiety. One staff member told us, ''I have to rely on staff that know people well to tell me how to support them if they become anxious. I don't find the care plans give me enough information to know what to do to prevent and de-escalate people's anxiety.'' Without detailed behaviour support plans in place to support staff to manage the risks associated with people's behaviour, people were at risk of not receiving consistent and appropriate emotional and

behavioural support.

The majority of people we spoke with told us they felt safe. However, two people told us they did not always feel safe when people living with dementia became agitated. They told us about incidents which had made them feel unsafe. They had not always felt reassured by the staffs' response following these incidents. Records showed the registered manager had discussed people's safety concerns with them however, an assessment of risk had not always been completed following specific incidents. Existing risk strategies showed no evidence of review following incidents to ensure these remained appropriate and people remained safe in the home.

When we spoke with staff about reporting behaviour incidents, all staff told us that they reported incidents. Incidents resulting from people's behaviour were recorded, for example, we saw records of incidents on people's individual behaviour charts and on incident and accident records. However, records showed these had not always been thoroughly investigated and for example, action taken to review people's risk management strategies in order to reduce the risk of similar incidents recurring.

Risks to people's safety had therefore not always been assessed, reviewed and plans were not always in place to ensure staff knew how to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the provider forwarded to us a document called a 'Specific Risk Assessment' in relation to the behaviour of one of the people referred to above. This had been completed after our visit and our feedback that we were unable to find relevant risk assessments in place relating to this person's behaviour. This assessment gave a brief description of what behaviour the person presented with and very brief guidance to staff on what action to take to reduce potential risks from this behaviour.

The Provider Information Return (PIR) stated that all staff had received training in safeguarding people. It stated that senior staff had received training at a higher level although the training record forwarded to us did not confirm this. This higher level of training involved knowledge of multi – professional policies and procedures when protecting people from abuse. Care staff knew what their responsibilities were in terms of safeguarding people from potential abuse and they were able to discuss these with us. There was evidence to show that safeguarding incidents had been discussed with the local authority's safeguarding team. The local safeguarding team, in these cases, had determined that these incidents did not require investigation by the local authority. They had been satisfied with the actions staff had said were in place to protect people.

However, incidents relating to the protection and safeguarding of people had not been notified to CQC as required and we had consequently been unaware of the number and type of incidents taking place. Where information is not appropriately shared with us, as is legally required, we are unable to sufficiently monitor services to ensure all necessary steps are taken to keep people safe. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Following an incident where a person who lived with dementia had left the service unsupervised, further risk management measures had been put in to place to prevent this from happening again. This person's liberty had been subsequently lawfully deprived in order to keep the person safe. However, following our visit we received information which showed that these measures had not been effective and the person had left the home unsupported again. We were informed that additional safety measures had been put into place to help keep this person safe. We shared this information with the 'supervisory body' and the county council's safeguarding team.

When people's mobility had declined their moving and handling needs had been re-assessed. For one person whose mobility had declined, the use of a hoist to safely move them had been decided on by a member of staff who had the skills to make this decision. A referral had also been subsequently made for an assessment by an NHS community occupational therapist. We observed staff hoisting this person on two occasions and they supported the person well. Staff had been trained to use such equipment. At the time of our visit we could not find or were shown a moving and handling risk assessment and relevant care plan to ensure staff would have all the information needed to support this person safely, including how to manage the person's anxiety whilst moving them. Following the visit the provider forwarded to us a moving and handling risk assessment. This had a recorded completion date on it which was prior to our visit and referred to the equipment we saw being used and how the person's anxiety would be managed when moving them. The provider subsequently commented, "The likelihood is that this was in the flat of the person concerned." They also forwarded to us another moving and handling risk assessment, for this person, which had been completed the day after our visit stating the use of the same equipment.

The provider and managers of the home considered there to be enough staff on duty in number to meet people's needs. On the first day of the inspection we observed staff to be busy and one member of staff specifically came to see us to say, "We need more staff, we cannot attend to all needs at once." However, we observed staff prioritising the support they provided to people. For example, if people were anxious, confused or needing to use the toilet, they were provided with appropriate support in a timely manner. At two meal times we observed staff having to support and manage too many people's needs. This resulted in people having to wait for their breakfast and at lunch time in another area of the home, one member of staff attended to four people's meal time needs and the behaviour needs of three of those people.

At the 'breakfast club' we observed 11 people seated at dining room tables waiting for their breakfast to be served. Twenty minutes later, eight people were still waiting to be attended to and some had made comment about the wait. More people joined the club as others finished. The one member of staff allocated to prepare and serve breakfasts worked hard throughout this time to serve people's breakfasts. At the same time one person required full support and supervision to enable them to eat their breakfast and to remain safe. This person lived with dementia and required guidance with their food, the use of their cutlery and at one point, to be removed from the kitchenette area in order to keep them safe. This support was provided by the one member of staff present apart from a short period of time when it was provided by another before they went to work elsewhere in the home. The member of staff managing breakfasts told us that the day before had not been so busy because less people had attended the 'breakfast club'.

The provider subsequently informed us that on the morning of our observation two members of staff had reported in sick and this had an impact on how breakfasts were managed. This shortfall had been rectified soon after the beginning of the shift when additional staff were sourced. The provider assured us that what we observed was an unusual situation.

In relation to the lunchtime observation the provider subsequently informed us that the reason that one of the two members of staff was absent some of the time was that they were serving food to three other people who lived on that particular floor. Although, as the provider informed us, this allowed for individualised service of food, it still left one member of staff to manage three people's behaviour needs alone. Potentially, with an open hot trolley in use, hot food being served and kitchen utensils in use this was potentially unsafe. At both busy times we observed the two members of staff remaining calm and they both had a good rapport with the people they were supporting. The provider has subsequently informed us that mealtimes have been reorganised. We will follow up the new arrangements in a future inspection.

Following feedback of our observations to managers they told us they had already identified that more

senior care staff were needed to help organise staffs' work. They told us once these staff were in place [which was to be soon] allocation and organisation of care staff and routines generally would be reviewed. Further senior care staff was also going to provide additional support and leadership at weekends. The Director of Care confirmed that moving forward admissions to the care home would predominantly be people with less complex needs. New admissions to the care home would be monitored by the Director of Care to ensure people's needs could be appropriately met whilst the home went through this transition. At other times we did observe people receiving the support they needed when they needed it.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable to care for them. Staff recruitment files showed the provider had sought appropriate references and explored prospective staffs' employment histories. This looked at the reasons for gaps in employment and why staff had left previous employment. Clearances from the Disclosure and Barring Service (DBS) were seen. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. These checks assist employers in making safer recruitment decisions.

People's everyday medicines were managed safely. We observed people receiving their medicines. People were supported to take their medicines and given explanations about these when needed, although two people told us they felt they had not been given enough information about their medicines. Medicines were administered by staff who had been trained to do this and whose competency in this task was reviewed regularly. We observed staff signing people's medicine records when people had swallowed their medicines. Some gaps in staff signatures had been found when records had been monitored, but this was being addressed. Ensuring people's medicine records were accurately maintained helped to protect people from medicine errors. There had been two medicine errors, both had been identified and managed without significant harm to the person involved. We spoke with staff about one of these errors and they were able to describe accurately how medicines should be managed. They explained what actions had been taken following this error to prevent a recurrence.

People lived in a safe and well maintained environment. A maintenance person was employed to carry out day to day maintenance jobs as well as some health and safety checks. They were supported by the provider's estates management team who managed more complex maintenance jobs and refurbishment work. It was the responsibility of all staff to help maintain people's health, safety and welfare and they had received relevant training on how to do this. There were well maintained records which recorded frequent monitoring and servicing of various systems and equipment. This included fire safety equipment and alarms, emergency lighting, call bells, the passenger lift, all other lifting equipment and utilities such as gas, electric and water. Risk assessments recorded the control measures in place to reduce risks associated with Fire and Legionella. Checks on the water system were carried out at regular intervals and a current certificate stated the water system was free from Legionella.

Some staff were appointed as fire wardens and they took a lead in co-ordinating operations in the event of the fire alarms sounding. All staff had received fire safety training. The training co-ordinator confirmed staff had been trained in the use of the evacuation equipment seen around the building. There was a Disaster and Evacuation information pack which gave staff guidance and points of contact to be used in an emergency situation. Guidance for the emergency fire service on what support people needed to evacuate the building was kept up to date and accessible. Emergency contingency plans were in place. In the event of an emergency support would be provided by the provider's head office staff and their other local care services.

There were arrangements in place to keep the care home clean and we observed the environment to be

clean when we visited. One member of the cleaning team told us about the measures in place to reduce the risks associated with the spread of infection. These included the use of colour coded cleaning equipment and the segregation of soiled laundry. We reviewed five infection control audits completed monthly. These showed consistently high scores in various areas of the audit, indicating that good infection control measures were in place and maintained. We also observed staff wearing protective gloves and aprons when delivering personal care and when serving people's food.

Requires Improvement

# Our findings

We checked whether the home was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had received training to help them understand the MCA and how they in practice should support people according to the MCA principles. We spoke with two care staff who had a working understanding of this legislation. Staff were aware they had to support people in the least restrictive way possible and understood the importance of giving people opportunities to make their own decisions. Throughout our visit we observed people being supported to make decisions and this included people who lived with dementia. People's permission was sought before staff delivered their care. For example, when one person needed to be moved by using a hoist we observed staff asking them first if they could do this. When the person indicated they did not want to be moved their decision was respected.

People were also supported in the least restrictive way. For example, people only received continuous supervision and monitoring from staff when it was required. When one person became agitated staff monitored their safety from a distance which allowed the person to continue to move about freely and go about their business. The service also used technology such as alarmed sensor mats and alarmed door exits as part of people's risk management strategies. This alerted staff to who was opening a door or moving around so they could check to see if that person needed support. These arrangements however were not designed to be restrictive and reduced the need for constant staff supervision.

One person's medicines were managed in the least restrictive way. We observed staff offering this person their medicines to see if they would accept them. Staff told us they would only hide this person's medicine in food if they refused to take them, as agreed with health professionals. This meant this person, who sometimes lacked capacity to make decisions about their medicines, was always supported to take their medicines in the least restrictive way. However, practice which protected this person's rights was not recorded in their care plan to ensure staff would always know how to support them in this manner.

People's records in relation to mental capacity assessments and best interest decisions needed to improve to be able to evidence that people and their legal representatives had been provided with the appropriate

support to aid their decision making. For example, two people's mental capacity assessments recorded they lacked mental capacity to understand the questions being asked of them and therefore make the necessary decision regarding their care. The records we inspected in relation to the assessment of these people's mental capacity did not go on to record if support had been provided in other ways or at other times to help them understand the questions being asked. In one person's case it would have been important for the record to demonstrate that all attempts had been made, through appropriate communication methods, to support them to make a decision because they were deaf. In the case of the person who was deaf the provider subsequently informed us that support was given to aid communication with this person in general. No additional evidence was forwarded to us confirming this had been the case when assessing their mental capacity.

Records did not show that people's legal representatives had been involved in all decisions relating to people's care, although the registered manager could explain how they had been involved. Several health professionals had also been involved in assessing one person's capacity and had considered it would be in their best interest to receive their medicine covertly (hidden in food or drink). The registered manager had discussed the best interest recommendation with their legal representatives. However, a record of the person's mental capacity assessment in relation to this decision and the options that had been considered as part of the health professionals' best interest decision had not been recorded. These therefore would not have been available for the legal representative/s to refer to and help inform their contribution to the decision being made.

Comprehensive records of the assessments carried out and decisions taken in relation to people's care and treatment were not always fully completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see whether the provider had either followed, or was ready to follow, the requirements in the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. Whether any applications under the DoLS had been authorised, and if so whether the provider was complying with any conditions applied to the authorisation. Where people had been deprived of their liberty in order to maintain their safety and to ensure they received the care and treatment they required, staff had made applications for DoLS to the 'supervisory body'. When these had been authorised the staff had correctly informed us. The authorised DoLS reviewed by us had no additional conditions in place.

People were cared for by staff who had received training and who had access to regular support (supervision) in order to support people effectively. The provider organised induction training, support sessions and refresher training on a regular basis. They employed a member of staff experienced in co-ordinating and delivering training to staff to organise this. All staff completed induction training when they first started work for the provider. This included an introduction to relevant policies and procedures. A mix of classroom training, computer modules and supervised practice was used. Subjects covered during induction included for example, fire safety, safe moving and handling, food hygiene, safeguarding people, health and safety and dementia awareness. The training co-ordinator was seen supporting one new member of staff to complete their training in safe handling of loads. One member of staff told us their induction had been "excellent".

Staff new to care were supported to complete the care certificate. This lays down a framework of training and support which new care staff can receive. Its aim is for new care staff to be able to deliver safe and effective care to a recognised standard once they have completed the course. Once staff had successfully completed their probationary period they continued to receive training, at intervals, in subjects relevant to

their role. The training record showed that staff continued to receive update training and that some had also completed additional training. This had included subjects such as person centred care, communication, end of life care and additional dementia care training. The provider was supportive of staff who wanted to develop professionally and provided them with opportunities to do this and then to take on lead roles in areas of particular knowledge or interest. Staff with a particular interest in dementia care had gone onto become dementia link workers. This had involved additional training in how to support colleagues with the care of those who lived with dementia in order to improve the standard of care provided to this group of people.

People were given the support they needed to eat and drink and to make choices about their food. One person told us that if you did not like or want the main option available, staff would bring something you did prefer. Another person told us the main menu was "monotonous" and they wished it was more varied. Another person told us the meals provided were "good" but the menus had become less varied. Managers explained that new menus had come into being with the new provider and were in line with the provider's other services and their food ordering arrangements. They explained the new provider had also introduced an "alternatives menu". This menu was available each day and had several different options on it. These included for example, jacket potatoes with various fillings, salads and omelettes. One person told us they could have a cooked breakfast [full English] when they wanted. We learnt this was available on three days of the week. We observed other breakfast options being served, which included a selection of cereals, fresh fruit salad, yogurts, boiled eggs and toast.

People's weight was monitored and any concerns about this or about people's appetite were referred to their GP. People had been referred to a speech and language therapist, for example, if they had problems with swallowing. Any advice subsequently given about how people should receive their food and drink was followed. For example, some people required a fork mashable or pureed diet and thickened drinks. Health professionals and the staff also helped support people who were diabetic to be aware of what was a healthy diet for them. People also had their blood glucose levels monitored. One person told us the "diabetic nurse" visited them regularly and took a sample of their blood for analysis. We visited the main kitchen where the staff were fully aware of what foods people required to maintain their health. Information sheets about people's individual dietary needs had been provided for the kitchen staff.

People's dining experience needed improvement. People were served their food without serviettes or anything else to wipe their hands with. One person brought their box of paper tissues with them because they told us they may need to wipe their fingers. There were no jugs of water or squash for people to help themselves to, although people's drinks were poured for them. There were no condiments such as salt and pepper on the tables. During one breakfast no cutlery was available on the tables and none provided unless the person was eating cereal, fresh fruit salad or yogurt, in which case the spoon came already placed in the bowl of food. People who had chosen to have sliced hard boiled eggs on toast picked up the egg up with their fingers when it rolled off the toast. The provider subsequently explained that some people found food they could eat with their fingers easier to manage. The lighting in one dining room was extremely dull. One person commented on this and said, "It is not very bright in this dining room." The staff member acknowledged their comment and we fed this back to managers. They told us this had already been identified and there were plans to address this. One person told us music usually played during lunchtime but this was not the case during the lunch we observed. The provider subsequently confirmed that music is usually enjoyed by people during lunchtime.

People had access to health professionals and adult social care support staff when it was required. People were supported by mental health specialists, occupational therapist and physiotherapists, including the provider's own physiotherapy staff. People had access to NHS dental and optical services. A chiropodist

visited on a regular basis to provide foot care, which people paid for separately. The NHS Rapid Response team had been involved when people had been taken poorly. This team can sometimes treat people immediately, in their own home, which sometimes can avoid an unsettling admission to hospital. To support the reduction of unnecessary admissions to hospital, an early warning assessment tool had been introduced. This triggered a process of closer monitoring of people by the home staff if they presented with health concerns. This enabled staff to give health care professionals more accurate information. Professionals could then act earlier to manage people's symptoms and hopefully avoid an admission to hospital. The Provider Information Return (PIR) stated that staff had received written praise from their local GP for their "excellent grasp of the medical needs of the residents in Royal Court."

Good

# Our findings

People spoke well of the staff, telling us they were "all very good" and "caring and sympathetic." They told us staff maintained their dignity and respected their privacy. They told us the staff were aware of their particular needs when providing their care. Another comment described the staff as being "fantastic" and another person told us they had always found all the staff to be helpful. They told us, if people were unwell the staff would help them back to their flats. People told us they felt able to talk with staff about anything that concerned them. Another person told us they "could not fault the staff."

In March 2017 a comment was placed on the website we reviewed by a person who lived at the home. They said, "The staff helped me adapt to the daily regime and I am quite happy with it. The staff are caring and interested in me as a person." A comment in April 2017 said, "Wonderful staff. Very caring and professional..... Always delighted with the care [name] received." A further comment made in July 2017 said, "The staff are caring, cheerful..... They always have time for you." One member of staff told us they liked being part of "a culture of person centred care and putting people first, making sure they are happy."

Although we observed staff to be busy we also observed them taking time to converse with people in a kind and meaningful way. Where people required time because they were physically frail or unable to follow instruction, staff were patient with them. When people were distressed staff responded to them and the situation quickly to try and reassure them or manage the situation. People who needed additional explanation or reassurance were provided with this. Staff spoke in a gentle way with people and were kind in their actions. People's dignity was maintained for example, staff placed aprons on people to protect their clothes when this was required and made sure their clothing was adjusted appropriately when they moved people.

People's right not to be treated in a degrading way was upheld. We observed staff speaking to people who were confused, disorientated and agitated in a calm and respectful manner. Staff gave people space to calm down and they did not belittle them. They adopted a non-judgemental approach when supporting people who were anxious and had become agitated. Staff understood that people who lived with dementia, might at times, use behaviour to make their feelings known when they could not easily find the words to express themselves. One member of staff said of one person who could become agitated, "[Name] is a lovely person it's just part of their dementia." People's toilet and personal hygiene needs were supported in a quiet and respectful manner.

Passing comments between staff and people showed there were established and good relationships

between them. Staff asked about people's families or people updated staff with their family news. Interactions were relaxed and familiar but remained professional. One person enjoyed the arrangement they had with staff where they would offer cutting of their plants to staff.

People's right to private family life was respected and we saw visitors being welcomed. One person confirmed they had never had any restrictions made on them with regard to who could visit and when they could receive visitors. There were no restrictions on visiting. If these were in place they would be as a result of best interests decisions following for example, safeguarding concerns. There were no such concerns at the time of our visit. People were supported to maintain relationships with those who mattered to them. One person's pet was extremely important to them and they had been able to come and live with the person in the home. We observed other people, to be fond of this pet. Taking an interest in where they were, what they were doing and stroking it. The home had internet access throughout the building which helped people who wished to remain in contact with friends and family through the use of electronic devices such as a laptop or mobile phone.

People were given choices and opportunities to make independent decisions. They could choose what they wanted to eat, how they wanted to spend their time, what activities they wished to take part in and who they mixed with. People who preferred their own company were afforded their privacy but staff remained aware of the dangers associated with self-isolation. The activities co-ordinator told us they tried to see most people each day, although sometimes this was not always possible.

There was evidence to show that people were supported to maintain their independence. Where possible and where people wanted to they were supported to use the local community independently or with support.

There was evidence in people's care records and other records reviewed by us to show that staff communicated with people's family representatives [if the person wished this to happen] and when a person lacked mental capacity. Relatives therefore had opportunities to speak on behalf of their relative when this was appropriate.

People's wishes were sought about how they wanted to be looked after at the end of their life. Staff had completed modules of training in end of life care and how to support the bereaved. Staff could access support from GPs and community nurses as people approached the end of their life to ensure people's holistic needs were met at this time. GPs had discussed with people [or their representative if appropriate to do so], the need for or their wishes with regard to do not resuscitate orders. Decisions about this were made on an individual basis.

Requires Improvement

# Our findings

People's care records did not always contain comprehensive care plans to show that their needs had been fully recorded and to provide accurate and sufficient guidance for staff on how to meet these needs. The provider had already identified a need for care plans to change as they wished to bring these in line with those used in other services managed by them. They had already taken action to provide staff with a 'Care Plan Summary' which gave staff an easy to read summary of the person's likes, dislikes, daily routine preferences as well as some other information. These showed that a particular effort had been made to gather personalised information about people. This helped staff to have meaningful interactions with people because they had relevant information about people to help them to this. Support to improve the content of existing care plans and then to complete more specific care plans, which included plans relating to the management of people's behaviour, had started to be organised. Following our visit the provider commented that immediate attention would be given to the improvement of people's care plans. They subsequently told us care records at Royal Court were to be brought in line with records used in their other services. We will follow these actions up in a future inspection to see if the action the provider was taking to improve people's care records had brought about the required improvement.

People, relatives and visitors were able to raise a complaint or area of dissatisfaction. The provider had a complaints and "grumbles" process in place. The complaints procedure seen during our visit had been reviewed in January 2014 and referred to complaints being made to the previous provider. The provider subsequently confirmed that the policy seen during the inspection was not the current version, which had been reviewed and updated in July 2017. A copy of the updated policy was forwarded to us.

We did not see around the home (apart from on a noticeboard on the ground floor) information about how to raise a complaint. We did not see any obvious guidance for people about what they should do if they felt dissatisfied about something and who they could contact if they needed support to voice their concerns. When we fed this back we were told decorating had been carried out and notice boards and their content had not yet been fully replaced. We were told that information about how to make a complaint was provided on admission to people. One person told us they were not aware of information being available to them about how to make a complaint, although, they personally would be able to raise any concerns they may have. Another person told us that when they had raised concerns they had not subsequently received any adverse care or responses from the staff for doing so. The provider subsequently confirmed that a copy of the complaints policy, entitled "Comments. Concerns, Complaints and Compliments" could be found in the "Welcome pack for residents" in each person's flat.

During the inspection we saw the service's "Log of Complaints" which provided a record of who made the complaint, the date it was received, what the complaint was about and in most cases a brief description of action taken and how it was resolved. However, for two complaints, based on the records seen during our visit and following additional information forwarded to us from the provider, we could not evidence that these had been appropriately investigated and addressed. Some improvement was needed to ensure records relating to complaints investigations would always be complete and readily available to support the provider to monitor whether complaints had been investigated in accordance with their complaints policy and to the satisfaction of complainants.

People's needs were assessed prior to moving into Royal Court. A pre-admission assessment policy made it clear that prior to any admission a person's needs would be assessed. It stated that the most suitable home to meet the person's needs, within the provider's group, would be suggested at this point. It stated a review would take place at twelve weeks, when the suitability of the chosen home would be reviewed with the person [where possible] and their representative. The admission assessment form had been recently revised to ensure it gave all the information required in line with this policy.

We were told by managers that reviews of people's care took place with them and/or their representative on a regular basis. One person's records showed that reviews had taken place with them and their family members. One relative supported there relative to make decisions about their care. The relative told us they had felt included by the staff in the planning of their relative's care but they were not aware of any specific process to keep them informed of changes or updates with care planning. The provider subsequently informed us that there were processes in place to keep relatives informed of changes. They told us these included for example, a communication sheet in each flat and if a relative did not visit, then changes in a person's condition and care could be discussed on the telephone.

People were supported to take part in social activities and other activities which were meaningful to them. One person told us that although they preferred to spend most of their time in their flat quietly, they were always informed about the activities due to take place. They chose which ones they went to and they enjoyed them. A comment made in March 2017, on the website we reviewed, by another person said, "The staff keep me informed of all activities going on in the house."

In planning activities staff were aware of people's specific needs, for example, reduced eye-sight, hearing loss, lack of ability to focus, inability to concentrate and retain information. Activities were adapted to meet these needs. One person told us staff were very aware of their disability and supported their needs around this. Staff had found out what people's particular likes and dislikes were in relation to how they spent their time. Information had been gathered from people, or their representatives, if the person had been unable to provide this, about previous interests and hobbies. An annual survey about activities also helped staff obtain specific information about what activities people wanted to be provided. Finding out what was meaningful to people also helped to support some individuals with their anxiety and subsequent behaviour. The activities co-ordinator explained specific activities were used to help distract and calm people and to try and alter their behaviour. The activities co-ordinator had started to evaluate the activities provided in order to see how appropriate they were for individuals, see if any changes needed to be made to support individuals and to get a sense of whether people had enjoyed them.

The activities co-ordinator told us they had designated time in the morning and afternoon for activities. At 11am each day a coffee morning took place where people could meet together with the activity co-ordinator and chat or complete a quiz. Activity times were split between group activities and supporting people on a one to one basis with a specific activity. For example, one person had wanted to go to the theatre so they went with the support of a member of staff. Other people enjoyed a walk or going shopping.

Group activities were decided on by those present for example, this may be a quiz, a game of hang-man or a mixture of other board games and adapted floor games.

Links had been made with the local community and were used by people. For example, a swimming club and library club had been started. Two people went swimming and four people went to the local library with staff. Links with community churches had been made to support people's religious preferences. The activity co-ordinator had also teamed up with their counterpart in another of the provider's homes. They organised party's and tea dances for their homes to jointly be involved in. The activities co-ordinator told us their role was well supported by the registered manager and other staff were becoming more confident in joining in with people's activities.

Requires Improvement

# Our findings

The registered manager and registered provider had some systems in place to monitor the quality of the service and to identify risks across the home that might impact on the care people received. However, the provider's quality monitoring process had not always been effective in identifying all the shortfalls we found.

The registered manager had not identified, prior to our inspection, the shortfalls we found in the management of risks during our visit. In particular those risks relating to people's behaviour, which could put them and others at risk of harm. A lack of comprehensive risk management processes had resulted in risks not being adequately identified and recorded. Actions put in place to reduce risks had not been regularly reviewed to ensure they were sufficiently effective to keep people safe. We found people's risks were managed by staff that knew them well, however, the risk management strategies were not always supported by robust risk management plans which reflected current best practice.

Although the provider's general audit looked at how many notifications had been made to CQC, the audit had not identified that not all necessary notifications had been completed and forwarded to us. There was insufficient monitoring of records completed to ensure people's mental capacity had been assessed correctly and that decisions, made on behalf of people who lacked capacity to make these decisions, had met the principles of the Mental Capacity Act 2005. The provider's monitoring systems did not identify that some records relating to some complaints were incomplete. Incomplete records did not always allow the provider to determine whether these complaints had been responded to appropriately and to the satisfaction of the complainant. Information received prior to the inspection and people's comments during our visit told us people had not always been satisfied with the responses they had received.

Other monitoring processes, such as the analysis of complaints and accidents and incidents required improvement. Repeated complaints about the support people received to remain safe in the home had been received. The provider had not sufficiently identified the trends and patterns evident in these complaints to improve the action taken to prevent further similar complaints being received. There was limited evidence to show that accidents and incidents were analysed in such a way which then led to robust preventative action being taken to prevent recurrences. Although, the Provider Information Return (PIR) completed in June 2017 told us this process had begun.

The quality monitoring process had not always identified risks to people, ensured the home remained compliant with the required regulations and ensured best practice had always been implemented. This is a

breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was evident through our conversations with the registered manager and Director of Care they were motivated to continually improve the service and were keen to take action to ensure good care was provided to people. The provider noted in their PIR that "a thorough and frequent quality assurance process and audits was being developed to ensure that all care and support is delivered in the safest and most effective way possible."

We found some checks and audits had been completed and improvements had been made. The last 'general audit' referred to as a 'snap-shot of what was happening in the home' was carried out by the Director of Care in June 2017. This referred to some actions which had already been planned. For example, we saw new care plans were being developed and the Director of Care would be reviewing progress on the implementation of these in their September 2017 audit.

Other audits, completed by staff in the home, showed that some effective monitoring had taken place and that areas for improvement had been identified. This was seen for example, in the infection control and health and safety audits and we also saw an example of how staff practice was monitored. The latter had been completed by the Director of Care.

People's views were listened to and gathered by the Director of Care and members of the board of trustees when they visited. The activities co-ordinator had used a survey to gather the views of people about the activities provided.

There were methods in place to provide the provider's senior management team with relevant information on a regular basis. This included a weekly report from the registered manager which included information about numbers of bed vacancies, complaints received, accidents and incidents and information relating to the management of the staff. A 'holistic monthly record' generated by staff in the home provided the senior management team with an update of each person's general health and welfare. This helped them to have meaningful conversations with people when they visited the home.

Staff spoke positively about working at the home and how managers communicated well with them. Two senior members of staff told us they worked with "a good team" who "worked well together." Another member of staff said they "loved working" at the home. They told us all staff were "very positive" about the management of the home. One member of staff described the registered manager as having been "absolutely brilliant" in supporting them. The registered manager had completed a leadership course specific to dementia care. This enabled them to lead the team of dementia link workers and ensure this particular resource in the home was used to benefit people who lived with dementia. Another member of staff said they had been "made to feel part of the team from the start." Meetings were held with people, their relatives and staff on a regular basis so managers could communicate with them and receive comments and suggestions back. The provider ran a staff forum and two members of staff had been elected by staff at Royal Court to represent them at this. This gave staff a direct opportunity to raise concerns or make suggestions to the senior management team.

During our visit we were informed of changes that were going to happen to the management of the home. People, their relatives and staff had already been made aware of these. The registered manager had accepted the role of assistant director of care for the provider. Plans were in place for promotion of the deputy manager to home manager from 1 October 2017. They would be applying to us to be the new registered manager. Interviews were taking place on one day of our visit for a new deputy manager. We were subsequently informed that the successful applicant would be in position in October 2017. Members of the

provider's senior management team were present in the home before we arrived and we were told they visited on a regular basis.

The provider had started a program of improvement and refurbishment to the building and grounds. A newly opened large conservatory area now provided extra space for people to sit and take part in social activities. We observed a large group of people, staff and visitors enjoying an afternoon party in this space. Staff told us this had made a huge difference to what could be provided to people in terms of activities. Two flats had been fully refurbished and offered improved accommodation and the plan was to refurbish all eventually. Areas of the care home had been re-carpeted and redecorated. New garden and patio areas enabled people to sit outside safely. Staff spoke positively about the improvements the new provider had started to make.

The provider and managers were aware that the layout and configuration of the building sometimes presented challenges when supporting people who lived with dementia. Plans were in place to address this but in the meantime some improvements had been made to help people orientate themselves. In one person's case, familiar pictures had been placed on their flat door. Part of one corridor had been designated to the care of those who lived with dementia. This had a keypad entrance and offered a secure environment for a smaller number of people. People who lived on this wing were also supported to use other areas of the home including the gardens. Additional security had been put into place.

# 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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Registered persons had not notified the Care Quality Commission of all incidents of potential abuse. Regulation 18(1) (2)(e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People's care and treatment was not always provided in a safe way. Not all that was reasonable practicable had been done to identify, assess, manage and mitigate risks to people. Regulation 12 (1) (2)(a)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes had not been established and operated effectively to ensure accurate and complete records were maintained with regard to the management of people's risks, care and treatment, decisions made about people's care and treatment and the management of complaints. |

The systems and processes in place had not always led to an evaluation of the information available with regard to the above. They had not led to an improvement in practice with regard to the above.
Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (f).