Healthmade Limited

Royal Court Care Home

Inspection report

22 Royal Court
Hoyland
Barnsley
South Yorkshire
S74 9RP

Tel: 01226741986

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13 October 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Royal Court is a care home providing accommodation and personal care to older people, some of whom are living with dementia. The service can support up to 40 people in one adapted building. At the time of this inspection there were 16 people living at Royal Court.

People's experience of using this service and what we found
Few improvements had been made since the last inspection. There continued to be many shortfalls in the service provided to people. There was lack of effective management and oversight of the service. There was no system to check the quality of the home and to drive improvements.

The design and layout of the premises did not meet the needs of people living with dementia. The décor of the premises continued to be tired and in need of a refresh. The provider told us they had a refurbishment plan in place.

People and relatives were happy with the care provided. One relative said, "Staff are lovely, marvellous and very caring. They are lovely with the residents." Staff were committed to the home and said they felt part of a team who could rely on one another.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 19 September 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not made enough improvement and they were still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 23 July 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the premises and equipment, staffing and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. In addition, we also followed up on concerns we had received since the last inspection in relation to the care of people living at the home and staffing.

This report only covers our findings in relation to the key questions 'is the service safe?', 'is the service effective?' and 'is the service well-led?' which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this

inspection were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the key question 'is the service safe?' We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of the is full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Royal Court Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the suitability of the premises, safe care and treatment and the governance system.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our effective findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Royal Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Royal Court Care Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager. However, after the inspection the provider informed us the previous registered manager had resumed working at the service and would be applying to re-register with CQC. If a manager is registered with CQC this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service short notice of our inspection. Due to the COVID-19 pandemic, we needed to check the COVID-19 status of the home and plan to enter the home safely to reduce the risk of infection transmission. Inspection activity started on 13 October 2020 and ended on 27 October 2020. We visited the home on 13 October 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback form the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan the inspection.

During the inspection
We spoke with six relatives about their experience of care provided. We spoke with nine members of staff, including the provider, the director, a senior carer, care workers, kitchen and domestic staff. We observed staff providing care, to help us understand the experience of people using the service.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of record relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We asked the director to send a substantial amount of records including training data, medication audits, rotas and records relating to quality assurance.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were enough staff deployed in order to meet people's care needs in a timely way. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

At this inspection we found some improvement had been made and the provider was no longer in breach of Regulation 18. However, further improvements were still required.
- There were enough staff to meet people needs and keep them safe.
- Staffing levels were calculated according to people's individual needs and feedback from people and staff was considered as part of this process.
- Comments from people about staffing levels were mixed. Comments included, "There's no staff in the launderette at the weekend" and "The cleaner only works three hours a day. "
- We spoke to the director about this and they confirmed that they were in the process of trying to recruit further staff to support with the cleaning and laundry tasks.
- Recruitment checks were completed, however there were discrepancies and gaps in the staff records. For example, we saw gaps in staff's employment history were not always fully explored and staff files did not contain evidence of an interview or induction taking place.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure accurate and complete staff records were maintained. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- People's medicines were managed safely.
- At this inspection, we observed staff administering medicines correctly.
- Each person had a medication administration record (MAR). This should be signed and dated every time a person is supported to take their medicines. We checked two MAR charts and found each had been fully completed.
- The audits carried out to ensure the safe management of medicines were not sufficiently robust and were not designed or completed in a way that would effectively identify and address any issues. For example, the audits did not include consideration of staff training and competence requirements, or medication reviews to check that the medicines prescribed were still appropriate.

We found no evidence that people had been harmed, however, the risks associated with medicines were not effectively managed because there was not a robust auditing system in place to monitor the safe management of medicines. This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents and incidents were not recorded consistently.

● The provider did not complete any analysis of accidents or incidents in order to learn from these events or identify necessary actions to improve safety. This limited the provider's ability to effectively manage the risks to people.

● There was no evidence that lessons had been learned since the last inspection. The risk of harm to people had increased. The provider has not taken action to ensure people received safe care.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure lessons were learned when things went wrong. This was a further breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections. Relatives told us they were asked to follow strict covid-19 prevention measures and restrictions were robustly in place for visiting their family members.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely. Infection, prevention and control measures were in mostly in place and staff understood safe procedures. However, staff told us they were wearing their own masks because they did not like the ones that were provided. On one occasion personal protective equipment (PPE) was not correctly worn. The director promptly reminded staff to ensure that the provided approved face masks were worn throughout all areas of the home.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Aspects of the environment did not support safe infection control measures. Carpets were worn and soiled, some furnishings were fabric which meant they could not be cleaned safely. Furniture, doors and skirting were worn exposing bare wood. The provider said they were in the process or recruiting additional cleaning staff to support enhanced cleaning within the home.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The service did not use agency staff and all staff had received training in the prevention of infection and control. However, there was no evidence of training completed to support the use of personal protective equipment (PPE). A risk assessment to support PPE in the current pandemic was not in place. The director said they would take immediate action to source further training.

● We were assured that the provider's infection prevention and control policy was up to date.

We found no evidence that people had been harmed, however, the risks associated with infection control were not safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach.

Assessing risk, safety monitoring and management

●There were risk management plans in each person's care record. These were detailed and regularly reviewed.
● Where risks were identified, the provider implemented actions to minimise risks and make improvements to safety; for example, by making appropriate referrals to external healthcare professionals and acting on their advice and instruction.
● When people's needs changed, risk assessments were updated to reflect this.

Systems and processes to safeguard people from the risk of abuse
● People and relatives said they felt safe and received good care. They were extremely complimentary about the staff who supported them. Comments included, "[Relative] is very safe, I have no worries," and "The staff are excellent and it's very safe."
● Staff told us they were aware of how to report unsafe practice. The provider had an 'Adult Protection and Prevention of Abuse' policy as well as whistleblowing guidance for staff.
● Staff knew how to protect people from the risk of abuse. Staff we spoke with confirmed they had received training in safeguarding adults from abuse. Staff were confident any concerns they raised would be taken seriously by the director and acted upon appropriately.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs.

At our last inspection the provider had failed to ensure the premises were suitable for the purpose for which they were being used. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not made enough improvement in this area and the provider continued to be in breach of Regulation 15.

●The décor of the premises continued to be tired and in need of a refresh as we had found at previous inspections.
● There continued to be limited signage and no points of interest to orientate people to where they were in the home which could be confusing for people living with dementia.
● Areas of the service used colours schemes for the environment that were not very dementia friendly. For example, similar colour tones used for the doors on storage rooms and communal bathrooms, which meant it could be difficult to distinguish between the two. In some corridors the handrails were not sufficiently contrasted against the securing wall.
● There were limited reminiscence pictures or tactile displays anywhere in the home. These can be a useful aid in supporting people with dementia.
● Some carpets, furniture and fabrics were heavily worn and stained. Carpets in some corridors had been taken up and not replaced, exposing bare concrete floors. Staff told us it had been like this for a number of months.
● Bathrooms contained equipment that had expired safety certificates and were not safe to use. These bathrooms were left unlocked and accessible to people living at the service.
● Checks of the building and equipment safety were not completed. For example, there were no records in relation to the checks of window restrictors, bed rails, mattresses and infection prevention and control.

We found no evidence that people had been harmed, however, the previous three inspection reports highlighted the premises were not suitable for the purpose for which they were being used. This has still not been addressed. Therefore, this was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider contacted us to say they had taken immediate action to address

some of the concerns we found on inspection and that they would ensure the carpet replacement programme would be implemented immediately.

Staff support: induction, training, skills and experience
● Staff told us they received the training and support they needed to carry out their jobs effectively. One relative said, "Staff are very skilled. They know what they are doing. The long-term staff are on the ball."
● Staff undertook mandatory training in key areas, such as mental capacity and moving and handling. Staff told us most training was delivered face to face at Royal Court, with some additional training completed via workbooks.
● Staff told us they received regular supervision sessions and staff told us they felt well supported by the director.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people were assessed at nutritional risk, referrals were made to health care professionals.
● Food and fluid charts were put in place to record people's diet if there were any concerns about weight loss or dietary concerns.
● Kitchen staff told us they worked to a four-week menu plan that included a variety of meals options. Some people had specific dietary needs for health or cultural reasons, and we saw these needs were catered for.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
● People told us they had access to medical professionals when this was required. Comments included, "Yes [my relative] sees a GP when they need to, and the staff always let me know the outcome" and "The [director] keeps me up to date with everything. They ring and ask me about [my relative's] care and whether to have flu jabs and COVID-19 tests."
●The service worked with health care professionals to meet people's care needs. Records showed people saw a range of health care professionals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw evidence on people's care records the director had visited people at home to assess their care and support needs to ensure they could provide an appropriate service.
● A relative confirmed to us the director had visited their family member at home and drawn up a care plan with them before they moved in.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any deprivations of

liberty had the appropriate legal authority and whether any conditions on authorisations to deprive a person of their liberty were being met.

- DoLS applications had been submitted when people had been assessed as not having capacity to consent to their care arrangements which amounted to a deprivation of liberty.
- Most care staff told us they had received training on the MCA and DoLS.
- People's care records contained consent to care documents. Where people did not have capacity to consent to their care, we saw their relatives or advocate had been consulted, as appropriate.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure governance systems had been fully established and operated effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not made enough improvements in this area and the provider continued to be in breach of Regulation 17.

- Prior to this inspection, the home had been rated requires improvement on the last three consecutive occasions and before that it was rated inadequate on three consecutive occasions. The home has been in breach of Health and Social Care Act regulations since 2015.
- The provider had not acted upon the concerns identified following our last inspection. Further improvements were still required with regard to the premises and the management of the service.
- There was a lack of clear and effective leadership. There was no registered manager in post. The previous registered manager left the service in October 2019.
- Quality assurance audits had not been routinely completed since the previous registered manager had left. We discussed this with the director, and they felt that the exceptional circumstances arising as a result of the COVID-19 pandemic had impacted on the management and oversight of the service.

We found no evidence that people had been harmed, however, effective systems were not in place to assess, monitor and improve the quality and safety of the services provided and ensure compliance with the relevant regulations. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The service did not promote a system of continuous improvement and learning.
- Incidents that occurred were not monitored in a way that would identify trends and patterns to prevent them from happening again.
- The quality assurance policy also stated that the manager and director would do a monthly 'walk around' of the service, speak to people, visitors and staff and document any areas of concern and take action where

required. There was no evidence of any walk rounds and the director told us this did not occur.
● The provider told us that since our last inspection they had been working to improve the service while managing the exceptional circumstances arising from COVID-19.Despite this, we found little improvement had been made and we identified the same or similar shortfalls we had discovered at our previous inspections.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Relatives told us the staff team were open and approachable. Comments included, "The [director] and the senior staff are very approachable. I can say what I need to" and "Staff are lovely, marvellous and very caring. They are lovely with the residents."
● Staff told us they enjoyed working at Royal Court and would recommend the service to friends and family if they needed this type of care and support. Some staff told us they had relatives who came to Royal Court to live or for respite care.
● Staff worked together and were supportive of each other. One staff said, "It's like visiting your family. Work colleagues are fantastic and are very supportive of each other. The residents are just like family."
● The provider continued to ensure the rating from their last inspection was clearly displayed on the premises.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristic; Working in partnership with others
● The provider and the director liaised with the local authority and health and social care professionals. The interaction with other agencies had been limited due to COVID-19 restrictions but virtual communication had been made when necessary.
● Feedback from relatives was extremely positive. People said they felt able to speak up about any concerns and were confident staff would listen to them. Comments included, "I can speak to [director] and staff when needed. I have a weekly telephone call and full update on [my relative]" and "Oh yes, I get regular updates, staff listen, and they are approachable."