Z.A.K. Healthcare Limited

Queens Care Centre

Inspection report

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13 April 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out 12 and 13 April 2017 and was unannounced on the first day. This meant the provider and staff did not know we would be visiting. The service was last inspected in July 2016 at which time the service was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was given a rating of 'Good' in all domains.

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

The service is required to have 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. At the time of this inspection we were told that the registered manager had resigned from their position a few days before. The deputy manager told us that they would be acting manager until a new manager is appointed.

Queens Care Centre is a purpose built home with accommodation situated on three floors. The home accommodates up to 67 people that requires personal care. It is situated on the outskirts of Rotherham in the village of Maltby and is close to local shops and amenities. At the time of the inspection there were 61 people living at the home.

Before this inspection we received information of concern from Rotherham council's quality assurance monitoring officer. Concerns had been raised about the management of medication at the home. We therefore brought this comprehensive inspection forward.

Care records were not always fit for purpose. Some lacked detail, were out of date or contradictory. When care records were reviewed, the reviews did not always result in relevant changes being made to people's care plans or risk assessments. We identified instances where care was not being provided in accordance with people's assessed needs.

Health professionals told us that communication within the home required some improvements. They told us their instructions were not always followed which meant people's care needs were not always met.

We found staff approached people in a kindly manner. However, most of the interactions we observed were task orientated. We observed people had to wait for assistance and staff were not always present in communal areas to ensure people's safety. This indicated to us that there were insufficient staff deployed to meet the needs of people who used the service.

People were supported by staff that had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Staff recruitment processes were sufficiently robust however staff did

not receive sufficient support and supervision. The acting manager told us they did not currently carry out annual appraisals with staff. This meant staff could not always discuss work practice and their own training and development needs.

The provider told us systems were in place to guide staff on safe administration of medicines. However, we identified these were not followed and people did not always receive their medication as prescribed. Protocols for the administration of 'as required' medications were not in place which meant people were not given pain relief at the times they required them. Medicines no longer required had not been disposed of as they should have been.

Risks associated with people's care had mostly been identified and plans of care were in place, however the risks associated with nutrition were not always followed. People were not always supported to eat and drink sufficient amounts to maintain a balanced diet and adequate hydration. We found the meal time experience did not meet the standards expected by the provider.

Activities in the home were infrequent. Relatives raised concerns about the lack of social stimulation.

Infection prevention and control policies were not always adhered to; therefore safe procedures were not always followed.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were in place to protect people who may not have the capacity to make decisions for themselves. However, we were told by the acting manager that they were unable to confirm who had authorised DoLS in place. We were unable to confirm renewals of authorised DoLS had taken place. Consent to care and treatment forms in the care plans we looked at had not been agreed or signed.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

The systems and processes in place to monitor the quality and safety of the services provided were not effective. There was a complaints procedure; however some relatives told us that they were not satisfied with the standards of care. One relative told us they were not satisfied with the personal care of their family member.

We found 6 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Individual risks to people were not always assessed or mitigated.

Staffing levels did not enable people's needs to be met in a timely way or in keeping with their preferences. Most staff were recruited safely but induction, training and supervision required improvement.

Medicines were not managed safely.

Infection prevention and control measures were not effective.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. However, we found consent was not always gained before care was given.

People's nutritional and health needs were not consistently met. Records were poor in relation to what people had eaten and drank.

Staff supervisions and yearly appraisals had not been completed for all staff, as required by the registered providers policies and procedures

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans were not always up to date. It was difficult to determine if people's wishes were listened to or respected. There was minimal information available about people's wishes for the end of their life.

Staff were task orientated. However, interactions we observed

were kindly. Respect for people's dignity was not always maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's health, care and support needs were not regularly assessed or reviewed. We found staff were knowledgeable about people's needs; however, most interactions were task led rather than person centred.

People were unable to access activities. We saw no activities taking place over the two days of the inspection.

There was a complaints system in place; and complaints had been investigated and a response sent.

Is the service well-led?

Inadequate

The service was not always well-led.

The registered manager had recently resigned from her position. Interim arrangements were in place for the recruitment to this role.

There was a distinct lack of communication, leadership and direction within the service which had not been identified by the provider.

The culture of the service was not positive, open and inclusive.

Health professionals told us communication required some improvement.

Audits and checks of practice were not effective in identifying and improving services delivered. Systems and processes were not effective to address where improvements were required to be made.

Queens Care Centre

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 12 and 13 April 2017 and was unannounced on the first day.

The inspection team consisted of three adult social care inspectors and we were joined on the first day by a quality assurance officer from Rotherham council.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information we received from notifications sent to the Care Quality Commission by the service. We also contacted Rotherham safeguarding to gather further information about the service. We spoke with an advanced nurse practitioner, community psychiatric nurse and a community district nurse who were visiting the service at the time of the inspection.

Prior to our visit we had received a provider information return (PIR) from the provider which helped us to prepare for the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the registered provider and acting manager, two senior care workers, six care staff, and two domestic staff. We also spoke with nine people who used the service and four visiting relatives. Some people who lived at the home were not able to talk with us about the care they received because they were living with dementia type conditions and had limited mental capacity. Observations helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at other areas of the home including the outside garden space, some people's bedrooms, communal bathrooms and lounge areas.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at seven people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service to assess if they felt safe in the home. Because most people were living with dementia some of their responses we have not been able to include. People that we were able to speak with told us they felt safe and they had no concerns or worries. They were clear they would speak to someone if they were worried or had any concerns. Some people said there were not enough staff at times and our observations supported this.

People's comments included, "I like it here, the majority of staff are okay. We sometimes have to wait for them to come, they do come eventually." "The staff are okay but there's not many of them." "Yes I feel safe here."

Relatives we spoke with told us that most staff were kind and caring but they were so busy that most interactions with people who used the service were task orientated. Relatives also raised concerns that some of the staff had left the service which meant some staff were new to the home and may not understand their family member's needs. One relative said, "There have been a lot of changes including the manager. They have relied a lot on agency staff which means the care is not always consistent."

We brought this inspection forward because we received information that people may not be receiving the medication as prescribed.

We looked at systems in place to manage people's medicines. Medicines were administered by staff who had received training to administer medications. Medicines were stored, safely and the temperature of the room was taken daily to ensure medication was stored as recommended by the manufacturer. However, we found three days over the last month where the temperature had not been recorded.

We checked controlled drugs (CD's); these are drugs that come under the requirements of the Misuse of Drugs Act. We found these were not recorded appropriately. Medication prescribed for one person to ensure they were pain free when approaching the end of their life had not been booked into the CD book. Another person who was prescribed a pain-relieving patch did not have the patch applied at the correct frequency. The patch should have been replaced every 7 days; however we noted a patch was applied on 28 March 2017 and the next patch was applied on 8 April 2017 when it should have been applied on 3 April 2017. This meant the person could have experienced unnecessary pain due to the delay in changing the patch.

We also found a person's anti-biotic and stomach medication was stored in the CD cupboard but had not been recorded as being at the home. The senior carer told us the name of the person who had never lived at the home but could offer no explanation why the medication had not been returned to the prescriber or destroyed.

Two boxes of paracetamols were also in the CD cupboard however these were no prescribed to any person using the service. These should have been recorded as a homely remedy if they were to be administered for people as pain relief. The acting manager told us that they did not use homely remedies but could offer no

explanation why they were in the CD cupboard.

We found another person had a supply of furosemide and movicol sachets in the medication cabinet. However, these were not listed on the current medication administration record (MAR). We asked the senior carer why the medication was in the cabinet and she told us that they had been stopped and no longer required. We checked a hospital discharge letter dated 24 March 2017 which clearly stated that the person was still prescribed the two medications. We checked the previous months MAR and found the medication had not been carried forward onto the current MAR. This meant the person was not receiving their medication as prescribed.

A relative we spoke with asked us to go to her family member's bedroom. We found two bottles of liquid anti-biotics which was prescribed for a person who no longer lived at the service. The relative was very upset as she feared that her family member may have taken the medication by mistake thinking it was prescribed for them. We later found that the senior carer had left it in the room as she was distracted while taking it to another room, which was used to return medication to the pharmacist.

We found people were prescribed medication to be taken as and when required, known as PRN (as required) medicine. We saw people did not always have PRN protocols. The protocols are used to explain to staff how people may have presented when they were in pain or agitated.

Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their capacity limitations. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs they may present with to determine when it was required.

Staff who were responsible for administering medication had received training to update their knowledge and skills. We also found periodic competency checks were carried out to make sure staff were working to expected standards, however we found concerns around the practice of staff in relation to medicines management.

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

Risk assessments were in place to identify the risks associated with people's care including nutrition, falls, moving and handling and choking. For people who lived with specific health conditions such as diabetes and dementia, the risks associated with these conditions had been identified. Plans of care in place gave staff guidance on how they should support people to reduce these risks, however we saw these were not always followed by staff. For example, one person's oral care should have been monitored every two hours. Staff had failed to ensure this regime had been followed.

Another person living with dementia had toiletries and sachets used for cleaning dentures in a basket in their on-suite. The daughter expressed concerns that she feared her family member may consume the liquids not knowing that they could be harmful. This had not been identified on the care plan as a risk. The daughter told us that she had asked for them to be locked away out of her family member reach but this had not happened.

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

We looked at the number of staff that were on duty on the days of our visit and checked the staff rosters to confirm the number was correct with the staffing levels they had determined. We saw that changes had been made on the second day of the inspection to cover sickness.

The acting manager had a 'staffing dependency tool' that was used to assess the number of staff required to be on shift each day in order to meet the needs of people who used the service. The tool showed each person's level of dependency and a score was then used to work out how many care hours needed to be provided each day. We saw the staff hours maintained were not in line with those identified as needed by the tool. Our observations on the day of the inspection were that staff were very busy and struggled to meet people's individual needs within an acceptable timeframe.

During our SOFI observation we found there was a 30 minute period during the morning when no staff members came into the lounge area. During this time people were sitting listening to music, which eventually finished. We saw one person was becoming agitated and was told by other people to "Be quiet" however there were no staff around to observe this. We could see staff were out on corridors getting people out of bed and generally looking very busy carrying out tasks. At no time during these 30 minutes did any staff come into the lounge to check if people were safe and well.

A second period of observation showed similar trends where people were left for 20 minutes without staff being present in the lounge. We saw one person had spilled their drink on the small table and was trying to mop up the liquid with a fabric apron. When staff arrived they paid no attention to people sitting in the lounge. They cleared away the drink without speaking to the person or offering another drink. Another person sitting in the lounge asked for a drink which was ignored by the staff member who then left the lounge.

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

Staff told us and records confirmed that they had recently received training in safeguarding vulnerable adults. We spoke with five members of staff who were able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. In addition, we saw evidence that the previous registered manager had notified the local authority and us, of any safeguarding incidents. Staff were also aware of the registered providers whistle blowing policy and told us they would feel confident in reporting any concerns they had to the appropriate person. Whistleblowing is one way a worker can report suspected wrong doing at work by telling a trusted person in confidence.

We checked how accidents and incidents had been recorded and responded to at the service. Any accidents or incidents were recorded on the day of the incident. We saw the recording form had the description of the incident and what corrective action was taken, along with how to reduce the risk of it happening again. It gathered information if further action was required such as attention from a health care professional or a referral to the falls assessment team.

We looked at six staff recruitment files and found most of the recruitment of staff was robust and thorough. However one file did not have the required recruitment checks such as references, application form or evidence of interview questions and responses. This member of staff did not directly deliver care to people who used the service. We asked the acting manager to obtain the missing records for the staff member. Inductions were mainly undertaken on site at the home. This included a period of shadowing more experienced members of staff. The acting manager was not aware that staff that had no experience in care should be registered onto the 'Care Certificate'. The 'Care Certificate' looks to improve the consistency and

portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

The acting manager told us that staff at the service did not commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to ensure only suitable people were employed by this service.

The home was a well-proportioned three storey building with plenty of space for people to move around freely. The environment had had some recent refurbishment work which had improved its appearance. During the day of the inspection there were some noticeable unpleasant odours in certain areas. We looked around the home and found some bedrooms had an unpleasant odour. For example one bedroom had stained carpet at the side of the bed which had a strong smell of urine. The bedding was badly stained with urine that had dried and when we examined the mattress we saw it was badly torn allowing urine to seep onto the mattress. We discussed this with the acting manager who told us they did not routinely check mattresses to make sure they were fit for purpose.

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

We saw regular checks of such things as electricity and gas installations, legionella and infection control had been completed. A fire risk assessment was also in place which helped to keep people safe.

Requires Improvement

Is the service effective?

Our findings

Some relatives we spoke with expressed concerns over the care provided. However, most said they thought staff were caring and friendly. They expressed that staff try to do a good job but they are often stretched so the quality of care is affected. One relative said they thought the regular staff were mostly good at their job but they said a number of good staff had left and they felt too many newer staff and agency staff were being used and this was not good for people who used the service.

Relatives we spoke with expressed mixed opinions on the level of involvement they had with the care planning process. One relative told us that they wanted to be involved but had not been given the opportunity to read or agree their relatives care plan. We saw some care plans had not been signed by the individual or their relative. Consent to care and treatment records had not been signed. Therefore it was difficult to confirm if people had been consulted about the care.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The previous registered manager, where appropriate had applied for people to have a DoLS authorisation in place. The acting manager showed us a record of DoLS that had been applied for (awaiting decisions) and also people who had a DoLS authorisation in place. However, the acting manager was unable to confirm if some of the DoLS had been renewed as the dates had expired.

We looked at one person's authorised DoLS which had four conditions that the provider had a legal responsibility to comply with. The acting manager was unable to provide evidence to confirm how the conditions were being met.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us staff had completed MCA and DoLS training and we saw evidence of this. Staff spoken with confirmed they had received training but their understanding of this was variable. Staff told us they would benefit from further training on this topic.

We saw in staff files an inconsistency in the records used to evidence that they had completed an induction programme. We spoke with one staff member who told us they had an induction period when they started working at the home. This consisted of shadowing other colleagues, reading policies and procedures, training courses and getting to know the home. They also told us about various training they had undertaken during their induction and since the start of their employment.

The training matrix showed the training courses each person had completed and what qualifications they had obtained and/ or were working towards. All the courses were relevant to their roles and included subjects such as dementia, vulnerable adults, manual handling and safeguarding, as well as a number of others. We saw some staff were overdue completing some topics at the frequency agreed with by the registered provider. Staff told us that they thought their induction and training had equipped them sufficiently to be able to perform their roles. They did however say that some training was cancelled at short notice. This was due to staff sickness and the priority was to maintain staffing levels.

Staff were aware of supervisions and appraisals and some were able to recall having these although they were unclear about the frequency. Other staff told us they had not had either supervision or an appraisal since they had commenced working at the home. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. Staff told us that they could voice any concerns they had at any time and would not wait until a formal supervision if there was something they needed to discuss.

The registered providers 'Supervision, appraisal and competency policy' stated that supervisions would be carried out a minimum of six times per year and that annual appraisals would not be completed. We looked at a supervision and appraisal matrix. We saw some staff had received some supervision's at various periods but the frequency of the supervisions differed between staff and were not in line with the registered provider's policy. The matrix also showed that staff had not received an appraisal in 2016.

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

We asked people about the support they received to look after their health. People told us, "I see the optician, the staff make me an appointment" and "I just need to ask and they sort it [healthcare] out for me."

We saw people were referred to other health services as required. A staff member said the home had a good relationship with the local district nurses and they could ring them anytime for advice or a visit to a person. Care records evidenced involvement from a number of varying professionals including doctors, memory team professionals, specialists and district nurses. This showed that people were supported with their health needs in a holistic way. We spoke with the community psychiatric nurse who was visiting on the second day of the inspection. They told us that staff made appropriate referrals for people who used the service. We also spoke with the advanced nurse practitioner (ANP). They confirmed that they regularly supported staff out of GP hours if they were worried about people's health.

People spoken with were complimentary about the food provided and felt the catering team did all they could to provide for and respect their preferences. People's comments included, "I love the food here and the portions are generous," "It's very good food, in fact so good I'm putting on weight," "The food is okay and if I don't like it I ask for something else," "The food is very good and I eat plenty" and "It could be better, but it's okay."

We observed the lunchtime meal being served. Prior to the meal being served people had been asked their preference between two main courses of either chicken and mushroom pie with potato croquettes and vegetables or chips sausage and beans. The food was served by the chef from a serving counter and looked pleasant in presentation. The catering staff and care staff were clearly aware of people likes and dislikes. People were offered varying portion sizes and special diets had been catered for.

The service had arrangements in place to ensure people received good nutrition and hydration. However, we found these arrangements were not always followed. We looked at seven people's care plans and found some had not been updated to reflect changes to the nutritional intake. Daily notes referred to one person as having a poor appetite. The assessment showed the person had lost over 1.5kg between 05/01/2017 and 08/03/2017 with a body mass index (BMI) of 17. However the nutritional risk assessment had not been completed for April 2017. Staff told us that the person's appetite was very poor. When we looked at the assessment it was clear that the person was given a score or four which meant the person should be monitored for fluid balance and meal chart in place. On further review of the record the person's BMI should have been 16 not 17 as recorded on the assessment on 08/03/2017. Based on our observations and discussion with staff the assessment score should have been recorded as eight which meant refer to dietician and GP. This meant that further advice should have been sought to ensure the person received adequate nutrition and fluids to meet her needs.

We looked at the food/fluid charts for this person and found they were only having sips of fortified drinks. We saw full beakers of drinks were taken away from the person's room who was cared for in bed.

We found the nutritional assessment for another person had not been completed. However staff said the person drank and ate sufficiently to not be at risk. Most people had a food/fluid chart which staff completed periodically during the day. We found the quality and detail of the entries varied which made it difficult to assess if people were receiving sufficient food and drink to meet their nutritional needs. Staff were unsure who had responsibility for monitoring the records but they thought it was the senior care worker.

The current best practice guidance for hospitals and healthcare services from the national patient safety agency states that, although there is no agreed recommended daily intake level for water in the UK, a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day. We were unable to confirm if people met their daily target.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives about the care they received. People that were able to talk to us in a meaningful way told us that most staff were nice but they said there were a lot of staff who they did not know. People told us, "The staff are great," "I get on with all the staff," "The staff are nice. They have their moments but normally they're okay," "The staff have made me feel at home" and "The care here is very good, much better than in hospital."

Relatives we spoke with said they found staff to care for their family members. However, one relative said, "You can never find staff to ask how they're [family member] keeping." Other comments received included, "Staff that have been here a long time know my [family members] but some of the new staff don't care as much," and "There just isn't enough of them [staff] and people living here need the extra support because they are living with dementia."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. However, we saw care staff had very limited time to spend engaging with people in a social way because they were busy carrying out physical care. One relative commented, "People are left for long periods without staff being present." Some people's rooms were personalised with their own belongings, such as photographs. Other bedrooms were very untidy and not very personalised.

A relative told us that they had requested a bathroom cabinet to be put up in their family member's bathroom. They said their family member was living with dementia and they had swallowed tablets used to soak dentures. By having a bathroom cabinet it would deter her relative from consuming substances that may be harmful. The relative told us their request had been refused.

We asked the acting manager if there was any reason the relatives request had been refused. He told us he was unaware that any request had been made. We looked at the care plan for this person and found there was no risk assessment recorded about putting toiletries out of the persons reach. He also said that he was unaware that the person had consumed any of the denture soaking sachets. Following the inspection the acting manager sent us a copy of the risk assessment they had put in place and had agreed that family could put up a lockable bathroom cabinet.

A relative told us that she had agreed with staff, when their family member was admitted into the home, that they would change their family member's hearing aid batteries every Monday to ensure they were working efficiently. They told us that this did not always happen and often during visits they found their relative was not wearing the aids. This meant staff were not respectful of this person's wishes and needs. The relative told us that without the aids their family member would not be able to contribute to conversations.

A relative also told us that they had requested two baths a week for their family member but said often when they visited it was evident that the bathing request had not been fulfilled. They said this would have caused their family member distress as they were always clean and tidy when they were able to care for themselves. We were unable to confirm when the person had been bathed from the care records we looked at.

During our visit we spent time in communal areas observing people who used the service and talking to relatives. We saw a lot of the time, staff were not in communal areas and people were left unsupported by staff. We observed one person very distressed as they had wanted to go to the bathroom. Staff acknowledged their request and said they would get a wheelchair. A number of minutes passed before they returned to assist the person. During this time, other people became agitated and started shouting towards the person to "Shut up."

We observed times where people's privacy was not maintained. We heard a member of staff shouting to another member of staff across a bedroom about the health condition of the person that was being cared for in bed.

We also observed a member of staff in the dining room displaying frustrations about supporting people with their meals. This did not show respect for people living at the service. Some staff did not knock on bedroom doors before entering. Although some of the rooms were unoccupied it is good practice to knock on all bedroom doors before entering.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

We asked people about the leisure opportunities provided. Comments included, , "I like to do things, but there's nothing to do here," "I go out with my daughter because there's not much going off in the home, "I spend my time smoking and listening to the radio because there's nothing else to do" and "I wish there were some activities as I end up just watching television."

One relative told us, "There doesn't seem to be enough activities, my [family member] would like to go on trips and outings." Another relative told us that their family member enjoyed activities but there was none available. They said, "When we visit we play cards and this occupies my [family member] but when we leave they just sit in the lounge without any stimulation."

The acting manager told us there was no permanent activities coordinator employed at the home. They said care staff were trying to provide some activities for people and they were currently advertising for an activities worker. On the day of the inspection we saw very little interaction between the staff and people who used the service. One staff member told us, "We do try to paint nails and spend time with people but we're always busy in a morning and evening so we try to do this if it's quiet in the afternoon."

We found people being cared for in bed were isolated. We saw the only interaction with staff was when people received personal care. We noted one person's bedroom was on the second floor but once people were dressed most spent the day on the ground floor. Staff were not deployed to the second floor during the day. This meant the person would find it difficult, if able to seek assistance from staff.

Not all people living at Queens Care Centre and their relatives were involved in planning their care. Some people spoken with were not aware they had a care plan. People told us, "I don't know about that [care plan] but staff seem to be writing all the time" and "I don't know anything about a care plan."

One relative said, "I have not been to any meetings about [family members] care since they came to live here but other family might have been."

The care plans seen showed that prior to a person going to live at the home an assessment of their needs was carried out. Following this initial assessment care plans were developed detailing the care, treatment and support needed to ensure personalised care was provided to people. Staff spoken with were able to talk to us about people who used the service and what their specific care and support needs were.

Care plans were reviewed on a monthly basis to ensure they reflected people's current needs and preferences. Daily notes were used to assist staff coming onto shift to familiarise themselves with any developments that had occurred that day. However we found the information in some care plans did not cover all aspects of people's care and support needs. For example in one care plan seen there was no information about the persons likes and dislikes. We also found there was little information in care plans in relation to making decisions, consent and capacity.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they were able to talk to the staff about any concerns or issues. They said they were confident staff would listen to their concerns and help them to resolve them.

Staff told us, "We can see the acting manager or senior care workers if we have a problem or need some advice."

The complaints log showed there had been no complaints made to the home since the last inspection. We saw there was a policy and procedure in place for any complaint's received to be investigated and responded to. The complaints policy/procedure was on display in the home and included in the 'service user guide.' The policy included the details of relevant organisations such as the local authority should people wish to raise concerns directly to them and included timescales for responses. We also saw the service had received compliment cards or letters in the last 12 months.

Inadequate

Is the service well-led?

Our findings

We found the service was not well led. We were informed that the registered manager had left the service on 8 April 2017 without giving notice. The deputy manager told us that they would be acting up as manager until a permanent manager could be recruited. We found staff lacked leadership and direction.

Staff's views of management differed but all staff spoken with said they had a senior member of staff they could go and speak to if they had any concerns or needed some guidance or advice. Staff told us that the previous manager was not visible in the home so they tended to go to the deputy manager for help and advice.

Supervisions were not undertaken at the providers required frequency and some staff could not remember when they last had formal supervision.

Health professionals and Rotherham quality monitoring officers all told us that they felt morale within the staff team was not very good. They told us the use of agency staff and changes to the management of the home had a detrimental effect on the service. We found some of the staff had not worked at the service for a very long time. This was because staff turnover had been higher than expected.

We saw daily records for all of the people who used the service were left on the window ledge in the lounge on the first floor. This meant that anyone in the home could read confidential information about people. We raised this issue with the acting manager early on the first day of the inspection; However the files remained on the window ledge for the remainder of the day.

In 2016 people who used the service, their relatives, healthcare professionals and staff were invited to complete an annual quality assurance survey. We found when these had been returned there was no report completed so that people were informed of the results and what action would be taken in response to their comments.

We found there was very little evidence of any effective system to monitor the quality of the service. Where audits had taken place, they were not effective in improving the quality and safety of the service or in identifying the shortfalls as described in the breaches illustrated throughout this report. Risk assessments were not effective and this affected the wellbeing of some people. For example oral care for one person and the monitoring of weight loss. The provider had failed to analyse these to identify any themes or pattern that may have resulted in a requirement to make referrals to healthcare professionals, such as dieticians. This, for example could indicate insufficient staff or ineffective deployment of staff however this had not been considered by the service and the provider had failed to monitor the risk to people who used the service.

We found serious concerns around the management of medicines and immediate action had not been taken to address the issues raised in this report. When we returned for the second day of the inspection the deputy manager told us it was on his list of things to do that day.

Infection prevention and control policies were not always adhered to. Bedrooms were not always effectively cleaned and mattresses were not regularly checked to ensure they were clean and fit for purpose. The provider audit dated 21/02/17 identified several problems with the cleanliness of the home. However the following audit dated 15/03/17 identified the same issues. Therefore the audits by the provider were noted effective in raising standards.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care that met their assessed needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not fully consulted about the care and treatment. Where people lacked mental capacity legal requirements were not always followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment and were not protected against the risks associated with the management of medications and infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The risks associated with people's nutritional and hydration needs were not well managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The provider has failed to deploy sufficient suitably competent staff to meet the needs of people who used the service. Staff should receive supervision and appraisals to develop their skills suitable for their role within the organisation.