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The Royal Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Royal Elms Care Home is a residential care home in Newton Heath, north east of the centre of Manchester. It can accommodate up to 25 people. At the date of this inspection there were 22 people living in the home.

This inspection took place on 15 February 2017 and was unannounced, which meant the service did not know in advance when we were coming. The previous inspection had taken place in October 2015, when the service was rated as "requires improvement". At that time, we found breaches of four regulations. These related to care records not being updated, consent to care not being properly obtained, issues regarding medicines and infection control, and quality monitoring systems. We asked the provider to submit an action plan, which we received on 21 December 2015. At this inspection we checked to see whether those actions had been completed. Further details are given in the main body of this report.

The Royal Elms had a manager in post since 2008, who had been registered with the Care Quality Commission since 2010. 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.

People told us they felt safe living in The Royal Elms. The building was adapted for the needs of people with reduced mobility. We considered that the stairgate at the top of one staircase posed an unnecessary risk. This was a breach of the regulation relating to safety.

Improvements had been made since our last inspection in relation to the storage of medicines. A sink had been installed in the medicines storage room. Medicines were administered safely.

Risk assessments were completed relating both to care and trips outside the home.

Staffing levels were acceptable. At the date of this inspection there was no cook and the registered manager and other staff were filling in.

Staff understood about safeguarding. Correct processes were followed when recruiting staff.
The home was kept clean and regular checks were made to restrict infection from spreading.

The home was protected against the risks of fire, and the building was well maintained.

New staff and existing staff received appropriate training. New staff were not yet following the Care Certificate. Supervision and appraisals were taking place to support staff.

Staff had received training in the Mental Capacity Act 2005 (MCA) but there was scope for bringing this up to

date. Consent forms were used to record that people consented to care, but when a person lacked capacity to consent, the form implied incorrectly that relatives could consent on their behalf.

Applications were made under the Deprivation of Liberty Safeguards (DoLS). One application had been made for someone nearing the end of life, which may have been inappropriate.

People liked the food. The lunchtime dining experience was enjoyable.

People's weight was recorded regularly. People had access to a range of healthcare professionals. The downstairs had been repainted in colours considered suitable for people living with dementia.

People living in the home and relatives told us they thought the staff were caring, and encouraged them to be independent. Staff were patient and knew the people in the home well. People were dressed in a dignified way. There was one exception but this was that person's choice.

Confidentiality was respected. The home was prepared to meet people's needs as they approached the end of life.

Care plans were thorough. They contained handwritten plans for each aspect of care. A new style was being introduced with typewritten plans, which were a little easier to follow. People's life history was recorded, where known, which enabled staff to engage with people.

There had been no formal complaints recently. People were able to approach the registered manager regarding minor issues.

There was a good range of activities provided in the home, and two staff responsible for delivering them. We saw a lively and enjoyable music and dance session. There were activities suitable for people with more advanced dementia, and the home had developed flash cards for people who could not communicate verbally.

Trips took place from time to time and there were regular pub lunches. People attended residents' meetings.

People living in the home, their relatives and staff all had a high opinion of how the home was run and of the registered manager. Many staff were long-serving but there were some new recruits as well.

A new audit system had been introduced, but several months of medication audits had been missed. Other audits were completed but there was no analysis of accidents. We saw one error in recording DoLS applications.

The provider visited the home but there were no records of those visits. This meant there was an absence of evidence of oversight of the home. Taken with the missing audits this represented a breach of the regulation relating to good governance.

The registered manager had been involved in one disciplinary matter recently. There were regular staff meetings.

We found breaches of two regulations 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 the full version of the

report.

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.

The building was suitable for its purpose, except that one stairgate was a potential hazard.

The storage and administration of medicines was safe.

Staff recruitment followed the correct procedures to ensure staff were suitable to work in the home. The building was well maintained and fire precautions were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was provided. The training on the Mental Capacity Act 2005 needed to be refreshed.

The form for recording consent was potentially misleading and needed to be revised.

People enjoyed the food. They had access to healthcare.

Is the service caring?

Good

The service was caring.

Staff displayed a caring and considerate approach.

People were encouraged to remain as independent as they could. They were in the main well groomed, well presented and dignified..

The home was able to care for people at the end of life.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and enabled staff to meet people's needs. They included information about people's life history.

There was a programme of activities within the home and regular trips out.

The system for recording complaints needed to ensure that informal complaints were recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

People expressed approval of the registered manager and her leadership of the home.

Audits had improved since the last inspection but there were some gaps. There was no record of scrutiny of the home by the provider or any other external auditor.

Staff meetings took place but there had been no recent surveys of people's views about the home.

The Royal Elms Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 15 February 2017 and was unannounced.

The inspection team comprised an inspector and an 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. This expert had knowledge and experience of caring for older people.

Before the inspection we asked the registered provider to complete a Provider Information Return (PIR). 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 reviewed the PIR along with other information we held about the service, including notifications received from the service and information from other sources. Services are required by regulations to notify certain events to the CQC. We contacted the relevant contract officer of Manchester City Council about any recent monitoring visits, but discovered there had not been any.

We contacted Healthwatch Manchester, who did not have any information about the home. Healthwatch is an organisation responsible for ensuring the voices of users of health and care services are heard by those commissioning, delivering and regulating services. We contacted the Community Infection Control Team of Manchester City Council, whose latest visit had been in February 2015, with another one planned imminently.

During the inspection we looked around the building and observed mealtimes and interaction between staff and people living in the home. We carried out an observation using a system known as a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

During our inspection we spoke with 10 people using the service, four visiting relatives, and six staff,

including the registered manager and deputy manager. We looked at three care records in detail. We also looked at records relating to staff, medicines management, building and equipment maintenance and the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people living in the Royal Elms whether they felt safe. One person said to us, "My daughter and I spent a long time trying to find a safe place for me to stay at, till we came here; I feel safe here and my daughter is happy." Another person said, "The home is safe for all of us; if I have a complaint I will go to [the registered manager]." A third person said, "The home is very friendly and warm. Nobody does any harm to you."

Relatives also commented positively on the safety of the environment. They said, "The home is adequately safe and clean for my [relative]" and "Staff always react promptly to buzzers and provide for [name]'s needs."

Following our last inspection as part of the action plan, the registered manager had sent us a refurbishment plan. Most of the refurbishment related to the safety of the building, in particular replacing carpets with non-slip flooring in the communal rooms downstairs and in the bedrooms. By the date of this inspection, we saw that most of this refurbishment plan had been accomplished, but five of the bedrooms had not yet been done. The registered manager told us that the bedrooms were refurbished when they became vacant, rather than asking people to move out of their rooms.

The building was not a purpose built care home but in most respects was adapted to the safety needs of people living in the home. However, one detail caused us some concern. The top of one staircase was adjacent and at right angles to the door of a bedroom. There was a stairgate at the top of the stairs which was level with the top of the banister. The stairgate was fairly low – approximately three feet high. We considered that the occupant of that bedroom might be at risk of falling over the stairgate when emerging from their bedroom or alternatively someone might attempt to climb over it. We discussed this issue with the registered manager who pointed out that this stairgate had been there ever since the home opened and had been seen by previous inspectors without comment. She added, rightly, that the staircase and bedroom could not be moved. Nevertheless, we considered that a higher stairgate could be positioned there in order to reduce the risk. We are recording this as a breach of Regulation 12(1) and 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in order to ensure that the work is done to protect people from the risk.

We were also concerned that people were at times sitting in the quiet lounge unattended. This room is close to the office but not in direct line of sight. We saw one person attempting to stand up from their armchair, staggering and nearly falling. We consider it would be advisable for the home to review this to ensure that the they are doing everything reasonably possible to keep people safe, especially when someone is known to be at risk of falling and sustaining injury.

We looked at how medicines were ordered, stored and administered within the home. Medicines were ordered on a four week cycle from a local pharmacist. They were delivered the week before the new cycle started, and the pharmacist came in person with the delivery to help check that the correct medicines had arrived. At our last inspection we found breaches of regulations relating to the physical condition of the

medicines store room, including the absence of a sink for staff to wash their hands when handling people's medicines. We found these issues had been put right, and a small sink had been installed. The medicines room was small but well organised. There was a new small fridge for storing medicines that needed to be refrigerated. We saw that the temperature of the fridge was recorded daily, as was the temperature of the room itself twice a day, to ensure that medicines were kept within the correct temperatures.

The medicines trolley was kept permanently in the medicines room, to which only senior staff held keys. This meant the medicines were kept securely. We saw that the staff administering medicines locked the door every time they left the room. There was a cabinet for controlled drugs which conformed with regulations, although at the time of the inspection no controlled drugs were being used at the home.

We observed part of the morning medicines round. The staff member was calm and efficient and followed good practices to ensure medicines were administered safely. Medicines were taken to people one by one, and the staff member explained what the medicine was for. One person told us, "Staff tell me what medication I am on but I forget the names. I can remember though that they give me my medication twice a day." Staff waited to check that the medicine had been taken before returning to the medicines room to sign the Medicine Administration Record (MAR). We saw that each person's MAR was signed immediately after their medicines had been given, as is correct practice. We checked a sample of MARs and saw that they had been fully completed.

At the last inspection we found a breach of regulations because the information available to staff about when to offer PRN or "as required" medicines was lacking in detail. These are medicines prescribed to be given when people are in pain or need them for another reason. On this occasion we found that clear instructions, known as PRN protocols, had been written and were accessible to staff alongside the MAR sheets. We saw PRN medicines being offered, and people told us they received them when they needed them. One person said, "I am on three to four tablets a day and if I have a headache staff give me something." Another person said, "If you are in pain, staff always give you something for pain." These quotes indicated that PRN medicines were given out when needed.

We found that the breaches relating to medicines found at the last inspection had been rectified and that the management of medicines was now safe and compliant with regulations.

We saw that a range of risk assessments were present in people's care records in order to protect them from risks. These included Waterlow risk assessments (which assess people's vulnerability to pressure sores), and risks in relation to malnutrition, falls, bathing, and moving and handling. We saw monthly reviews of these risk assessments in care files. We also saw a risk assessment had been written for a trip to Blackpool and for earlier trips, which meant risks of taking people on trips had been assessed and actions planned to mitigate those risks in advance.

We asked about staffing levels. On weekdays there were four staff present, including the registered manager and a senior care assistant. The registered manager told us she was "hands on" and was involved in delivering care. For example she served breakfast every day. At the time of the inspection she was in fact making the breakfast, because the long-serving cook had left in January 2017 (after 16 years) and the service was in the process of appointing a new cook. This meant that there was one member of staff fewer at breakfast, because the registered manager was in the kitchen rather than helping to serve the meal. We considered that another member of staff could have been brought in to cover during the cook's absence.. At lunchtime someone did come in to make the lunch, which freed the registered manager for her other duties.

The Royal Elms never used agency staff. There were bank staff who could be called on when needed. They

were used in the event of holidays or planned sickness, or alternatively staff might be asked to do extra shifts. If someone was sick at short notice, the registered manager would try to find a replacement or if necessary one of the senior staff would fill in.

At weekends there was one senior and two care assistants on duty. At night there were two staff who were 'waking nights' meaning they stayed awake all night. In our last report we raised the concern that there might be times when two staff were not enough, especially if there was some kind of medical emergency. The registered manager explained to us that there was always a senior on call who could attend the home quickly, for example if someone needed to go to hospital.

The service was not using a formal dependency tool to assess people's needs and the level of staff needed to meet them. Their view was that they knew people well because it was a small home. Our observation showed that staff were able to manage but were stretched at times especially in the absence of the cook in the morning. We acknowledged that this was a temporary situation until the appointment of a new cook but likely to be for a number of weeks. We were not aware of any safeguarding incidents in the last 12 months where shortage of staff had been an issue. People living in the home and their relatives told us they thought there were enough staff and they could always get hold of a staff member if they needed to. We concluded that staffing levels were sufficient to meet the current needs of people and the regulation but the registered manager should monitor people's needs and review staffing levels regularly and request the provider to authorise extra staff in advance of when needed, for example until a new cook was recruited.

All staff with the exception of the two most recent recruits had received recent training in safeguarding. Staff we spoke with understood the meaning of abuse and told us they would report any abuse they witnessed or suspected to the registered manager or to another authority if necessary. We saw safeguarding was discussed as part of team meetings and staff supervisions. This should help ensure that the people who used the service were protected from abuse.

We looked at the records of three newly recruited staff to check that the recruitment process was effective and safe. Prospective staff completed application forms. However, the application form did not specifically ask job applicants to account for any gaps in their employment history, which is best practice. The registered manager told us she would ask questions about any unexplained gaps in the job interview. We confirmed this from records of interview. We noted that candidates were asked to spend time with people in the home and then people were asked their opinion of the candidates. This involved people living in the home in the recruitment process.

Pre-employment checks had been carried out. These included checks with the Disclosure and Barring Service (DBS), which keeps a record of criminal convictions and cautions, which ensures that employers have relevant information about potential employees. We noted that copies of the actual DBS certificate were retained on staff files. The certificate is the property of the employee and best practice is not to retain a copy. We mentioned this to the registered manager. We saw on file health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer. This meant that recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service.

In the infection control report by Manchester City Council, dated February 2015, the home had scored 85%, a high score. Actions following that report, and actions following our last inspection in October 2015, had been undertaken. The deputy manager was designated infection control lead. We saw records of checks carried out to ensure all areas of the home were clean. While we were there the home smelt fresh and looked clean. All the rooms and communal areas we saw were clean, as was the kitchen. One visitor had

recorded in a questionnaire, "The cleanliness is excellent. The home does not smell at all. That is excellent." The infection control lead checked that the cleaners had completed their tasks and ensured there was a system for doing deep cleaning of bedrooms in turn. There had been an outbreak of sickness in May 2016 which had been reported to Public Health and handled in the correct manner.

People were protected against the risk of fire. The fire risk assessment was reviewed annually. Fire alarms, fire doors, extinguishers and emergency lights were checked and tested regularly. There were fire doors throughout the building which closed when the fire alarm went off. There had been an inspection by Greater Manchester Fire and Rescue Service in June 2016. Their report dated 23 June 2016 identified minor breaches of fire safety regulations, for example that a heat detector should be replaced with a smoke detector. We saw that this and other recommendations had been carried out by the home.

A file was kept in the office with a register of the names of people living in the home, to give to the fire service in the event of a fire. There were details of what help people needed to evacuate the building, known as Personal Emergency Evacuation Plans (PEEPS). These were in two different formats. The newer ones included too much information and were difficult to decipher. We discussed this with the registered manager who agreed to revert to the old format which would be more accessible to the fire service in an emergency.

We saw records which showed that the building and equipment were well maintained. There was evidence that the boilers were serviced regularly. Electrical systems were checked, and portable appliance testing (PAT) was done. The water system was checked for the presence of legionella every twelve months. Water temperature was tested. The lift was maintained regularly, as were hoists and slings. This meant that people were protected from the risks associated with poor maintenance of the building and its equipment. We noted that the plastic roof above the balcony outside the dining room required cleaning as it looked unsightly.

Requires Improvement

Is the service effective?

Our findings

We asked people living in The Royal Elms whether they thought the staff were well trained, and received only positive responses. For example one person said, "Staff seem to know what they are doing." Another person said, "Staff are just excellent."

We looked at records of training and supervision to see how well staff were supported in their roles. New staff did shadowing as part of their induction training. This meant they observed how other staff were working and learnt from them. New staff's training needs were assessed individually, and training prioritised according to their previous experience. The registered manager used a variety of training providers. This included trainers visiting the home, and staff attending a local college. The provider was in the process of setting up online training for staff.
We saw from the record of training that all staff with the exception of the newest recruit had received training in core topics, namely moving and handling, first aid, infection control, safeguarding, food hygiene, fire safety, dementia care, Mental Capacity Act 2005 and medication (for senior care workers). We observed that the last moving and handling training for care staff had been in November 2015, but best practice is to renew it annually. We saw evidence that training in this topic was scheduled for 9 March 2017. There was also training in fire safety scheduled.

The majority of staff had done training in dementia care in July 2016. The registered manager told us she had arranged further training in dementia awareness for all staff but this had not been delivered. However, three senior staff were currently undertaking dementia care training with the Gold Standards Framework (GSF), a provider of training in end of life care and related subjects.

A district nurse commented in a questionnaire in 2016, "Staff are well educated and liaise with healthcare professionals well. There are no improvements I feel at present need to be made as services here are meeting all needs of residents on the district nurse caseload."

We asked to see the supervision record which confirmed that supervisions had taken place every three months during 2016. Supervisions provide an opportunity for line managers to meet with staff, feed back on their performance, identify any concerns, and offer support, assurances and learning opportunities to help them develop. Supervision was given either by the registered manager or the deputy manager or one of the senior care assistants. Staff confirmed the supervisions had happened, and we saw examples of completed supervision records which were detailed and showed that individual issues were addressed. The same record confirmed that annual appraisals had also taken place in 2016, which meant that staff were supported to look back over the year as a whole and discuss their aims and objectives for the year to come.

We looked at how well the service was applying the principles of the Mental Capacity Act 2005 (MCA). 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

All the care staff apart from recent recruits had received training in understanding the MCA. However, the deputy manager, two of the three senior care assistants and three of the seven care assistants had last received this training over two years ago, so the service needed to find ways to maintain and update people's knowledge.

We observed staff asking for people's consent prior to them providing any care or support. Staff explained how if someone declined support, they would leave the person and try again later, or another staff member would try. People's ability to consent to aspects of their care had been recorded in their care plans. The policy on the MCA stated: "Staff should check that service users' consent remains valid for each treatment or care given prior to commencement." The policy was detailed although it came from a commercial supplier and it required updating as it referenced the regulations issued in 2010 rather than the current regulations issued in 2014.

We saw that consent forms were used to record people's consent to various aspects of care. We saw that some forms had been signed by the person themselves, but there was also space on the form for a relative to sign, with the wording "On behalf of the person. Relationship to the person…" This created the impression that a relative could give consent on behalf of the person living in the home. This is not the correct procedure under the MCA. One person cannot give consent on behalf of another who lacks capacity to consent themselves, unless they have the relevant power of attorney for health and wellbeing. There needs to be a best interests decision, which can involve the relative, but they are not the sole decision maker. We discussed this with the registered manager who understood the principles involved and that a best interests decision needed to be made when a person lacked capacity to consent. This was also stated in the service's policy: "where a service user lacks capacity in relation to these issues we will take steps to ensure that decisions are made in their best interests." We concluded that the correct processes were being followed but the wording on the consent form required to be changed to conform with the MCA.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

The registered manager supplied the provider's policy on DoLS which gave clear guidance on when to apply for a DoLS authorisation. However, she also stated to us: "People need to have a DoLS because they have dementia." That is not an accurate explanation of the purpose of the DoLS scheme. DoLS authorisations should be applied for not because someone has dementia, but because they are being deprived of their liberty, and lack capacity to consent to that deprivation. The least restrictive option should always be sought.

We saw evidence that seven DoLS applications had been made relating to people currently in the home, and the application forms were correctly completed and gave sufficient detail. None of these six applications had yet been granted. The most recent application was for someone who was approaching the end of life, and we discussed with the registered manager the question whether it was appropriate to make an application in those circumstances. This was partly because (until April 2017) if someone dies when a DoLS authorisation is in force, the death needs to be investigated by a coroner. Department of Health guidance (which we later forwarded to the registered manager) suggests that a DoLS application may not be appropriate in the last weeks of life. The registered manager withdrew the application at the end of our inspection.

People told us they enjoyed the food. One person said "I don't have to ask what's on the menu, staff put it on the board. They make a nice dinner; I like it when they make curry." Another person said, "The food is not bad, I like their braising steak with vegetables. There is always some choice, like some time ago they were serving a cheesy meal which I didn't like, staff made me something else, I didn't have to do it myself, staff did it for me." Other comments were, "The food is alright, they give me nice meals with good variety. I got my two Weetabix and toast this morning" and "Dinner was smashing."

In the temporary absence of a cook a part time member of staff came in to make the lunch. There was a choice of two dishes: pork steak or fish cakes, with cauliflower and mash. The registered manager was planning to introduce daily menu sheets with pictures of each dish. In the meantime, people were offered the choice verbally in advance. The food was well presented, appetising and warm. Most people were sitting at dining tables which were laid attractively and were enjoying conversation. We saw that people who needed help with eating received it. One person said to us, "Staff know me well; they cut my steak in small pieces for me as I can't use my arm strength as well as I used to."

The home had received a food hygiene rating of 5 at an inspection on 20 July 2016, which is the highest rating available. People's dietary needs were met. We saw that the care plans recorded people's specific needs and health conditions, and we were told this information was communicated to the cook although in their absence we could not verify this. Both the registered manager who made breakfast and the staff member who made lunch said they knew people's needs.

Everyone was weighed monthly, or more often if needed, and if weight loss was a concern people were referred to medical professionals. One person told us their health was maintained: "It is a good thing I moved here; staff give me pain tablets for my knees and call the doctor for me when I need one." We saw from care records that people had regular access to healthcare professionals to look after their general health needs. Records were kept of visits to or from healthcare professionals including dieticians, the district nursing team, opticians, GPs, chiropodists, the mental health team, physiotherapists, and speech and language therapists. People also went regularly to the dentist. We were assured that people's healthcare needs were being met proactively and as required.

We looked at the environment for people living with dementia. The downstairs areas had been repainted, following comments in our last report. We were told the service had consulted the King's Fund regarding the colour scheme. This is a resource for providers of services for people living with dementia. We considered there was scope for larger and clearer signage. There were names and pictures on some bedroom doors, to enable people to identify their bedrooms. Where the pictures were not present we were told the people had taken their own pictures down. These developments showed some thought had been given to the needs of people living with dementia. There was a large garden area, at the back which appeared unkempt. There were no signs that it could be used in warm weather. People could safely access a decking area outside the dining area, near the front door. This was used as a smoking area. There was also a small smoking room upstairs.

Good

Is the service caring?

Our findings

We asked people living in The Royal Elms about the standard of care they received. One person said, "Let's just say I couldn't manage without staff caring for me the way they do." Other people said, "Staff are very good; you can have a laugh and a chat with everyone" and "It's good to live here. It is only for certain people, and staff know that, that's why they are supportive." Relatives we spoke with tended to agree: "Staff are always welcoming, efficient and caring."

Our own observations were that staff were dedicated to their caring role. Outside meal times they appeared to have time to stop to chat with people and were not constantly rushing from one task to another. We saw that staff were kind, patient and considerate when supporting people and meeting their needs.

People told us they were encouraged to be independent. One person said, "I do everything for myself. Staff don't mind if I decorate my room the way I want it. As you can see it for yourself, I got my own flowers and pictures." They added, "Staff always ask you what you like." Another person said, "I do everything I want, when I want, except going out, staff have to be there or I go out with my daughter."

Some of the people living in The Royal Elms were living with dementia and unable to express their thoughts and feelings to us. To understand their experience we conducted an observation to watch how well they were cared for. We saw that staff had developed close relationships with the people in the home. They talked to people with kindness and encouragement. Some people were dozing in their armchairs but staff checked from time to time to see if they were comfortable. We saw that staff ensured that people had drinks. We observed some considerate interactions between staff members and people during the lunchtime period. Those who needed help or encouragement to eat were given it in a gentle and patient manner. This meant that the staff treated people with dignity and respect. We saw one person who was quite distressed repeatedly asking "When can I go home?" and stating their address. A member of staff gently and kindly explained to them why they were in the home and how they were being looked after.

People were on the whole well dressed and well groomed. Staff evidently encouraged people to maintain their dignity. There was one exception; a person whose tracksuit bottoms descended very low at the rear as they were leaving the breakfast table. We asked the registered manager and deputy manager about this. They said it was a regular event; the person had capacity and insisted on wearing these loose tracksuit bottoms. The managers had talked to the person about keeping them hitched up at the back but it seemed to be an ingrained habit. We appreciated the difficulty but it did reduce both the person's dignity and that of others who witnessed them moving round the home.

The laundry was in the basement, and the laundry system was explained to us. Clothes were labelled and sorted so that people would receive back their own clothes. People told us of one or two occasions when they had been given the wrong clothes, but these were not common. One person said, "I always get my own clothes back." This meant that people rarely or never wore other people's clothes which showed that the service understood the importance of maintaining people's dignity. Another person said, "Everything is lovely, washed and ironed."

We saw on staff files that new staff signed an agreement about confidentiality. Care files were kept in the office which meant they could not be accessed by visitors to the home except with the registered manager's knowledge. We saw that when staff were working on the files in other areas, they were careful to ensure that the files were overseen by another member of staff if they were called away. This showed that they respected the confidentiality of the information in people's files.
We did not see any record of advocates being appointed, but the staff demonstrated their awareness of advocacy and explained the provider's policy was to ask for an advocate to be appointed if the person had no family members to represent their interests.

The service was ready to provide end of life care when needed. The staff had not received specific training in end of life care but told us they would work closely with district nurses as and when needed. Although some people had died in hospital we knew from notifications received that some people stayed in the home. One person had returned from hospital for palliative care in the home. Anticipatory drugs had been used. These are special controlled drugs which are used at the end of life to control pain and assist with breathing for example. We were informed the person had died peacefully surrounded by their family.

At the time of our visit there was one person with a DNACPR form in place. This is an official form which instructs paramedics and staff not to attempt cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest. The form needs to be readily available because without it paramedics are obliged to commence CPR. The form was not on the front of the person's care file, where we would expect to see it, but in the district nurses' file. We were assured that all the staff knew where it was and would direct paramedics to find it if the need arose.

Good

Is the service responsive?

Our findings

We looked at three care files in detail. Each file contained a document called 'My life story' which contained detailed information about the person's childhood, upbringing, working life and family life. The amount of detail varied according to how much the person themselves or family members had been able to contribute. In two of those life stories we saw there was ample information to enable staff to engage with people about their past life in a meaningful way.

The care plan was divided into different sections covering all the necessary aspects of care, including personal hygiene, mobility, continence, medical/nursing needs, pressure area care, mental health, eating and diet, bathing, finances, social contact, and sleeping. All of these sections were thorough and detailed; our only concern was that they were a little hard to decipher in places as they were handwritten. The registered manager showed us a new style care plan that she was creating. This was typewritten and was easier to follow. So far only one person had a care plan in this format.

There were also risk assessments relating to aspects of care: falls, moving and handling and pressure area care. These were reviewed monthly. The care plan itself was reviewed every month, although similar wording was used each time to describe the result. Daily notes for each resident were kept in separate files which could be accessed easily by staff and visiting professionals.

Relatives told us they had been involved in the care planning process, in addition to contributing to the 'My life story'. One relative said, "[Name] is my [relative's] keyworker. They always keep me informed about my [relative's] condition." Another relative said, "I visit often, staff never miss an opportunity to update me, they know [them] very well and whenever I come in staff can always convey how they are] feeling to me." A third relative said, "We are reasonably involved in [name's] care plans."

We considered that care plans were adequate to meet the needs of people living in the home. The staff were stable and knew people well, which assisted them to deliver good quality person-centred care.

We asked to see the record of complaints and were told that no formal complaint had been received since 2014. Both people living in the home and their relatives told us they would not hesitate to go to the registered manager if they had any issues. One person said, "In the last six months, I never had any concerns. If I had one I will mention it to one of the staff." Another person said, "I tell staff or my carers when I am not happy."

One person referred to a problem that had occurred, and described how the registered manager had resolved it: "I complained to [the registered manager] that one of the residents who is forever wandering about has stolen my coat, and I told her that if I don't have a key for my bedroom door I don't feel safe – she went out the same day and cut me a key, I feel safer since." This indicated that the service had a proactive approach to dealing with complaints. However, the complaint ought to have been recorded as part of the system to monitor the service and drive improvement.

The care files included an 'activities passport' which listed activities that people liked or might like to participate in. Two care staff were responsible for activities and entertainment. They used an activity recording file which listed everyone's names, with a copy of their activities passports, and recorded feedback from both individual and group activities that had taken place.

There was a week's activity planner on display in communal areas. This included mainly indoor and group activities for both morning and afternoon sessions such as memory games, bingo, exercises, movie night, fish and chips, Sunday songs and cake decorating. On the day of our inspection the planner showed floor games. In the morning we observed people engaged in floor games with soft and colourful bean bags whilst singing along to wartime music such as 'Run, rabbit run', 'When the saints go marching' and 'It's a long way to Tipperary'. In the afternoon the residents were enjoying singalong whilst swinging pompoms, playing tambourines and dancing to music from a later era such as Elton John's 'Can you feel the love tonight' and 'How deep is your love' by the Bee Gees. The session was being enjoyed by 13 people in the lounge and staff were engaging with everyone, even the quietest and the oldest who were at one stage dancing in the middle of the lounge, smiling and swinging along.

There were things planned to occupy those people who tended to wander about. For instance staff left a basket of towels and tea towels on the window sill along one of the corridors. We saw two people, who at different times, stopped by the basket and folded those towels. Staff told us this was something they had encouraged people to do.

One of the staff involved in activities said, "Balancing caring and activities is very challenging, especially when everyone wants different things, but we try our hardest to keep everyone happy." The other staff member added, "We have organised zoo lab [animals brought into the home(and) walking in the park for bird watching. We are also in the process of applying for Ring and Rides facilities; we managed to get passports for seven residents." They added, "We do raffles and jumble sales to raise money for outdoors trips." We saw a four week time table for pub lunches. Several people told us they particularly enjoyed pub lunches, which they went to by taxi. One person recalled, "Last year we went to Blackpool and a chip shop, on a coach."

We saw that the home used a system of flash cards, designed within the home, to assist communication with those people who had difficulty communicating verbally. These had a "Yes" and "No" for people who could just point, and included names of well-known local places, shopping centres, theatres, cinemas and parks. TV programmes were listed. There were cards with different kinds of clothes to enable people to choose what to wear and others with items such as hair brush and make up kit. There was a body map for both females and males, for people to point at when they were in pain or discomfort. Other cards included days of the week and months. There were images to depict different emotions e.g. shapes to use for when they are sad or cold.

We considered the flash cards were an excellent innovation given that they had been devised by staff within the care home.

We found evidence that people were given choice in relation to the activities of daily living. One person told us, "Sometimes staff take me to the dining room and sometimes they let me have my food in the lounge." Another person said, "I do most things for myself, staff allow me some choices." A third person said "I get up when I like." These views showed that people were treated as individuals and allowed freedom to choose, provided their choices could be accommodated.

We saw minutes of residents' meetings which took place every two or three months. One person said, "I

attended the meeting, I always wanted to tell them things but when I get there I forget what I wanted to say, but I always talk to [the registered manager] , she always says 'If you have any problems, come talk to me.' She is good that way." Someone else said, "I do go to meetings, I can't remember what we talked about."

The above evidence showed that people were involved in decisions affecting their daily lives, as best they could be.

Requires Improvement

Is the service well-led?

Our findings

We asked people what it was like to live in The Royal Elms, and whether they thought the home was well managed. People told us they liked the home and gave positive feedback. One person said, "I have been in this place about three years, and I've got nothing bad to say about the place. The atmosphere is so good and the staff keep you informed." Another person said: "The atmosphere in the home is alright. I am settled well; it is good to have a place like this one, to help you cope."

Relatives we spoke with also had a high opinion of the home. One said, "The home provides a caring atmosphere, with [the registered manager] being very informative and very approachable." Another relative said, "The care home is joyful; I've never seen staff miserable." These sentiments were echoed by the staff, who told us they were happy working in the home. One said "We are a good team; we support each other."

Both residents and relatives expressed approval of the registered manager. One person said, "She is very friendly, and very approachable, she tells us about everything." Relatives said, "She is wonderful, we have seen many improvements," and "She is warm and always keeps us in touch." The registered manager told us she made it her aim to be accessible, and she would usually serve breakfast in the dining room in order to see directly how everyone was doing.

Our own observation was that staff engaged well with people. They were enthusiastic in their tasks. Most staff had been at The Royal Elms for many years, including the deputy manager who had worked there for 22 years. There were also newer recruits, who appeared to have absorbed the same work ethic.

A new system of audits had been implemented since the last inspection. We looked at the records of medication audits. We saw that the registered manager had picked up on some issues that needed to be rectified, for example that a photograph was needed on one person's file, and that there had been a recording error. An action was identified on the audit for example "Photo required", but there was no corresponding note to say this action had been taken. One concern was that the audit was intended to be done at the end of each month, but the record showed that it had been missed for three months between August and November 2016. We asked the registered manager who admitted she had not done them in that time. This meant that medication errors might have occurred during those months but not been identified.

We saw that the format used for care plan audits had changed from September 2016 onwards. The audits used prior to that date had been more detailed and more effective. More issues had been noticed during the previous audits. We discussed with the registered manager the advantages of returning to the more detailed type of audit.

The handyman did regular checks of health and safety issues such as the safety of wheelchairs, the call bell system and the operation of window restrictors. In addition, there was a detailed health and safety audit every six months. We saw the last two audits were thorough. In addition a range of infection control audits were done, covering bedrooms, mattresses, toilets and bathrooms, the dining room, lounge, hand hygiene, and the laundry.

We also saw a file marked 'accidents audit', but on examination it was a collection of accident reports. In other words there was information about individual accidents, rather than any analysis of common factors or patterns, which might contribute to a reduction in future accidents. There was space on each accident report for an 'Action plan' but this was rarely completed.

Although care records were generally good, we found one concern. We found one copy of a DoLS application on a care file but no record of it in the file of DoLS applications. This had the potential to cause confusion.

We asked whether the provider visited the home and whether they made any recommendations. We were told they visited once a month for a whole day. There was a file labelled provider visits but there was nothing in it. The action plan submitted after the last inspection stated, "The proprietor will provide a written report from his visits on a monthly basis." This did not appear to have happened. There had been no other external auditor of the home. This meant there was a lack of oversight and scrutiny of the running of the home.

The absence of governance at provider level including oversight and scrutiny of the quality monitoring systems, coupled with the missing months of medication audit, and issues relating to DoLS records and the lack of an accident audit, amounted to a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked whether there had been any disciplinary issues. The registered manager told us she consulted the provider about human resources issues. There had been one issue in the past year where staff appealed successfully to the provider following a decision made by the registered manager. The registered manager felt she had been put in a difficult position, but there had been no issues relating to those staff more recently.

Staff meetings were held regularly, sometimes for all staff, sometimes just for senior staff. We saw from the minutes that a lot of information had been imparted to staff, but there had also been the opportunity for them to raise matters. The registered manager told us, and staff confirmed that they were free to approach the registered manager at any time. We saw that the office door was usually open when someone was in there.

The rating from our previous inspection was clearly visible in the entrance porch to the home. The Royal Elms did not have its own website so the requirement to display the rating there did not apply. We asked to see surveys of residents' and relatives' views but were not provided with any evidence these had taken place.

We discussed with the registered manager the requirement to report certain incidents to the CQC. These include deaths, serious injuries, safeguarding incidents and the outcome of DoLS applications. These were in general reported appropriately. We discussed some notifications of DoLS outcomes where the form used had left out a vital question (about whether the application had been granted). The registered manager assured us this would be rectified from now on.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that the premises were safe to use for their intended purpose, because a stairgate posed an avoidable risk to service users Regulation 12(2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight and scrutiny of the quality and safety of the home Regulation 17(1)