Helene Care Limited

Helene Lodge

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

Helene Lodge is a care home without nursing for up to six adults with learning disabilities. There were five people living there when we inspected. It is a detached house in a residential area, with a paved garden at the back and a gravelled parking area in front. The building is not wheelchair-accessible, although people living there are able to walk around independently. Accommodation is located on the ground and first floor, which is accessed by stairs. Each person has their own bedroom and some bedrooms have ensuite facilities. Shared facilities include two lounges, a conservatory, a kitchen/dining room and a toilet and bathroom on the first floor.

The previous registered manager stepped down in July 2014 and has since left. A new home manager has started in post but has not yet applied to register. The service is required to have a registered manager as a condition of its registration. 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 our last inspection in April 2014, we asked the provider to take action to make improvements to staffing and to their assessment and monitoring of the quality of the service. They sent us an action plan that stated they

Summary of findings

would meet the relevant legal requirements for staffing by 29 July 2014 and for assessing and monitoring the quality of the service by November 2014, after the new fire alarm system had been installed.

At this inspection, people told us they liked Helene Lodge and its staff, whilst relatives expressed mixed views. Staff treated people in a caring manner, respecting their privacy and dignity, but our findings did not all match the positive views we heard. There were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People's assessed needs were not fully met because there were not enough staff on duty. There was no system to adapt staffing levels to people's changing needs. Because of this, people had limited social opportunities outside of day centres, in the evenings and at weekends. Staff were not always able to fulfil all the duties expected of them as well as meeting people's support needs. This was a repeated breach of the Regulations.

Additionally, there were continuing shortfalls in the provider's quality assurance and risk management systems. Action had not been taken to address risks to people's health, safety and welfare. Repairs remained outstanding and water from some taps was dangerously hot despite having been reported by staff. There was no system for people, relatives and staff to give their views about the service and have these addressed. Information from quality assurance surveys, incidents, comments and complaints was not used to improve service quality. Audits of the service were not robust and actions arising were not followed up. This was a repeated breach of the Regulations.

Whilst there were minor scuffs to paintwork on walls and doors, and worn settee covers in one of the lounges, the décor was reasonably intact. However, some aspects of the premises required attention, including broken electrical fittings and the heating in one person's room.

Staff received basic training, but did not have regular, documented supportive meetings to discuss their work with a manager.

Care plans were not kept under review and were not all sufficiently detailed for staff to be sure about the support people needed. They did not fully reflect advice or instructions from health and social care professionals about how to support people safely. People's risk assessments had not been reviewed and updated regularly or in response to accidents or incidents. This meant staff might not have been aware of particular threats to the person's safety and wellbeing and how best to manage these.

Staff were aware of how to report concerns that someone could be experiencing abuse. However, reasonable steps had not been taken to identify or prevent the possibility of financial abuse.

Medicines were not stored securely, and handwritten medicines administration records (MAR) were not checked to ensure they contained the correct instructions.

Most areas of the house were visibly clean, but one bathroom was dirty, with faecal staining on the toilet. Soap and towels were not available in the upstairs shared bathroom for people to wash their hands after using the toilet. The infection control policy did not address the matters required by the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections.

Some records were inaccurate and incomplete, which meant that staff and managers did not have all the information they needed in order to provide the care people needed or for the management of the service.

Additionally, we identified areas where improvements could be made. These related to person-centred care planning, screening for malnutrition and documenting consent to medicines.

Summary of findings

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

People were not always kept safe.

There were not always enough staff on duty to meet people's needs.

Reasonable steps had not been taken to identify or prevent the possibility of financial abuse. People told us they felt safe and staff were aware of what action to take if they were concerned that anyone was experiencing abuse.

Repairs needed to keep the premises safe and comfortable had not all been identified or undertaken. Medicines were not stored securely and appropriate standards of cleanliness and hygiene were not maintained in all areas.

Is the service effective?

Requires Improvement

People were supported effectively, although we require and recommend some improvements to the service.

Whilst staff said they found their managers supportive, structured supervision meetings did not happen regularly and concerns raised were not always acted upon.

Where people lacked the mental capacity to make decisions about aspects of their care and support, staff were guided by the principles of the Mental Capacity Act 2005 to ensure that any decisions were made in the person's best interests. We have made a recommendation about documenting people's consent or best interest decisions in relation to taking medicines.

People were supported to have enough to eat and drink and to maintain a balanced diet. We have made a recommendation about malnutrition risk assessments.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and supported them in a calm and friendly way.

People were able to make choices and staff listened to them.

People's privacy and dignity were respected. Staff supported them to keep in contact with their families and encouraged them to do things for themselves.

Is the service responsive?

Requires Improvement

The service was not fully responsive to people's needs.

Summary of findings

Care plans were not sufficiently detailed in order that staff could be sure of the support people needed, although staff had a good general understanding of people's support needs. Care plans did not always reflect advice from people's health professionals about how to support people safely.

Risk assessments and care plans were not reviewed and updated in response to people's changing needs.

People had limited opportunities for socialising outside the house during the evenings and at weekends.

We made a recommendation regarding involving people and their circle of support in planning their care.

The service was unable to demonstrate learning from complaints and lacked a system for learning from people's or relatives' comments or concerns.

Is the service well-led?

Inadequate

The service was not well led.

Risks to people's health safety and welfare were not all identified or acted upon. There had been delays in attending to hazards and breakages identified in maintenance checks. Hot water at some taps was dangerously hot. Quality assurance systems had not detected the shortfalls found at this inspection.

There was no system to improve the quality of the service and manage risks through regular feedback from people, relatives and staff. Adverse findings from a quality assurance survey in 2014 had not been acted on.

Records were not all complete, available or stored securely.

Helene Lodge

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 26 and 30 January 2015 and the first day was unannounced. It was carried out by two inspectors on the first day, with the lead inspector returning on the second day. We returned on 6 February 2015 to give feedback.

Before our inspection we reviewed the information we held about the service, including notifications of incidents the provider had sent us since our last inspection in April 2014. We also spoke with the local authority social services contract monitoring team. We did not request a Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we met and spoke with all but one of the people who lived at Helene Lodge. We also spoke with three relatives, the home manager and another member of staff, the nominated individual and the provider's managing director. We observed staff supporting people in communal areas. Following the inspection we received feedback from five health and social care teams and other agencies involved with people's care and support.

We looked at three people's care records and all five people's medicines administration records. We also looked at records that related to how the service was managed, including three staff files, staff rotas for the week of the inspection and the previous two weeks, and the provider's quality assurance records.

Following the inspection, the nominated individual sent us copies of policies and their staff training summary, as we had requested.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Helene Lodge.

At our last inspection in April 2014 we found there were not enough qualified, skilled and experienced staff to meet people's needs. Sufficient steps had not been taken to ensure that people on duty were suitably skilled in order to safeguard people's health, safety and welfare.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they would ensure there were sufficient qualified, skilled and experienced staff by 29 July 2014.

At this inspection in January 2015 we again identified concerns relating to the availability of skilled and experienced staff to meet people's needs.

People's assessed needs were not fully met because there were not enough staff on duty. There was no system operating to adapt staffing levels according to people's changing needs. Although people went to day centres and had occasional trips out with staff, regular social activities such as clubs and evening events rarely happened. One person told us they liked to go to a club but "can't go out when they're short of staff." They hoped more staff would come in at the weekends "so we can go out a bit more." Their care plan stated they went to the club every other weekend and enjoyed discos with people from other care homes. Their care records contained no evidence of this having happened in January 2015. A member of staff told us the person used to go out on a Saturday evening but they were not sure when or why this had stopped. Another person's deprivation of liberty was authorised on condition they had 'more 1:1 time to encourage participation in activities'. However, no one-to-one time was accounted for in the duty rota, which listed only one member of staff on duty at a time for all the people living at Helene Lodge, including cooking and cleaning. Staff told us people did not have many social opportunities at the weekends and during the evenings. They confirmed there was usually only one staff member at a time on duty, although a manager sometimes came in and took people out on an ad hoc basis or for occasional prearranged trips. Only one of the people living at Helene Lodge was able to go out alone safely; the others needed staff to go with them.

There were not always enough staff on duty to follow the provider's policies. For example, if a manager was not on duty it was not possible to obtain a second staff signature for people's cash transactions in line with the service user finance policy. Had anyone required medicines that were controlled drugs, staff would have been unable to follow the provider's medication policy, which required two staff to sign for controlled drugs.

Staff were expected to prepare meals and clean in addition to providing care and support. On occasions this meant staff were not able to meet people's needs. Staff reported they were very busy on their shifts, particularly in the mornings and evenings when the four people who went to day centres returned home, as well as at weekends. A record in the handover file following the first day of the inspection stated a person who did not go to daycentres missed their daily activities 'as the new cleaning rota took up all my time and I still did not manage to get all of it done.' Milk ran out during the inspection, and the communication book contained entries about low stocks of household goods such as toilet roll. Urgent shopping would be difficult for a lone member of staff to manage if everyone was at home. A recent incident form recorded that two people became distressed after an incident and one later had a seizure. At the time the staff member had been cooking the evening meal and another person was asking for assistance with the Wii games machine. It would have been extremely challenging for a lone worker to meet everyone's needs and manage the situation safely, although on this occasion a new member of staff was present working a shadow shift.

Staff sometimes worked long stretches on duty without a break, because they were working alone without a colleague to take their place. This meant there was a risk that staff might not get adequate rest to help them work safely and effectively. Additionally, whilst staff could telephone a manager for support, immediate practical assistance to manage incidents and emergencies was not always available. Rotas were organised in four shifts: 7am to 10am, 10am to 3pm, 3pm to 9pm and an overnight 'on call' shift where staff slept on the premises. Staff rotas for the week of the inspection and the previous week showed

a new support worker, who had just completed their induction, rostered continuously from 3pm Friday 23 to 3pm Tuesday 27 January 2015, including 'on call' shifts. When we arrived on Monday 26 January 2015 this staff member told us that someone else should have been on duty instead of them but had needed to swap their shift. The staff member had a break that afternoon as their colleague had arrived.

There were three regular staff employed: the manager and two support workers. Absences were covered by staff from the provider's other services or occasionally by agency staff. At the end of 2014 one member of staff had requested payment for leave they had been unable to take, which indicated there were not sufficient staff to run the service safely whilst allowing for holiday breaks. Temporary staff, who would not be familiar with people's current support needs, did not have access to accurate and up-to-date risk assessments and care plans.

These shortfalls in staffing were a repeated breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were often too few staff available to support people in the way they needed.

Following the inspection, the provider informed us they were increasing staffing, with an additional member of staff on duty mornings and evenings and at weekends.

Staff files contained the required information, including details of Disclosure and Barring Service (DBS) criminal records checks, employment histories and references. Initially there was insufficient information about the level of DBS check for one staff member but this was later provided; the check had not identified any concerns.

Staff were aware of how to report concerns that someone could be experiencing abuse, and the contact details for local statutory agencies concerned with safeguarding adults were displayed prominently in the office.

However, reasonable steps had not been taken to identify or prevent the possibility of financial abuse. We found receipts for people's expenditure in the filing cabinet going back to April and May 2014. Whilst receipts were sorted for each person by month, they were not stapled to people's completed cash records in accordance with the provider's service user finance policy and procedures. People's cash records had not all been audited in order to identify and account for discrepancies. When we returned to give feedback, cash records had been audited and receipts attached.

Cash records for each person were maintained and signed by staff, who said they checked the cash balance was correct whenever they took out or replaced a person's cash. However, forms were often signed only by one staff member, even for people who lacked the capacity to sign the form themselves. This contravened the provider's service user finance policy and procedures, which stated that a second member of staff must sign the cash record in such circumstances, in order to verify the transaction.

These shortfalls in cash recording were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they made people more vulnerable to financial abuse.

Whilst there were minor scuffs to paintwork on walls and doors, and worn settee covers in one of the lounges, the décor was reasonably intact. However, some aspects of the premises required attention. Moss had grown on the paved back garden and fallen leaves had accumulated, presenting a trip hazard. Hot water temperatures from some taps used by people living in the house had exceeded 60oC since November 2014, according to temperature logs maintained by staff. This was above the safe range to avoid scalds, which the log identified as 43oC plus or minus 2oC. We raised this with the nominated individual during the inspection; following the inspection the provider informed us they had arranged for the installation of temperature regulators to ensure that hot water was at a safe temperature.

The radiator in one person's room was not working. Staff had recorded this as an urgent matter a month before, when the weather was very cold; an oil-filled electric radiator had been provided as a temporary measure. A heating engineer visited on the second day of our inspection for the annual boiler service and said that repairs would be needed to the pipework. Following the inspection the provider informed us they would get quotes to repair or replace the heating system.

On the first day of the inspection, we saw a handwritten notice stuck over the light switch for the downstairs toilet

Is the service safe?

instructing staff not to use it. The light fitting was broken. This had been listed in the maintenance folder on 19 November 2014 but had not been actioned. A maintenance person had already been scheduled to visit that week, but when we returned for the second day, following the maintenance visit, this had not been repaired. After the inspection, the nominated individual told us they had locked the door pending a repair.

These shortfalls were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as inadequate maintenance of the premises and surrounding grounds did not protect people against the risks associated with unsafe premises.

Medicines were not stored securely. There was a locked cabinet used solely for storing medicines but this was made of wood and there was play in the hinges of one of the doors when it was locked, hence the cupboard was not secure. It was situated in direct sunlight, which presented a risk that medicines would be overheated and lose their efficacy. On the first day of our inspection there was a medicine that needed cold storage loose in the kitchen fridge. On the second day this was stored in a locked container. There were no suitable storage facilities for controlled drugs, should these ever be required. These medicines storage facilities did not meet the requirements set out in the provider's medication policy. The home manager had identified through a recent medicines audit that medicines storage was not adequate. When we returned to give feedback, the management team informed us that a purpose-built medicines cabinet had been ordered.

Some people were prescribed medicines on an 'as necessary' (PRN) basis. For some PRN medicines people had written guidelines so staff knew when and how to use these. However, such guidelines were not in place for all PRN medicines. For example, one person had a laxative medicine prescribed PRN but there were no guidelines as to the circumstances in which this should be used.

Medicines administration record charts were mostly supplied by the pharmacy pre-printed with the medicines, dosages and time each dose should be given. The current MAR at the time of the inspection had all been initialled by staff to indicate people had taken each medicine at the appropriate time and there were no unexplained gaps.

However, one person had a MAR for painkillers that had been handwritten by a member of staff. This had not been countersigned as a check that it had been written out correctly and this contravened the provider's medication policy. There was therefore a risk that the person may not have received their medicine in line with their doctor's instructions.

These shortfalls were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was a risk that unauthorised people might have access to medicines and that people might not receive their medicines as prescribed.

Appropriate standards of cleanliness and hygiene were not maintained in all areas. Many parts of the house were superficially clean, including the kitchen. For example, communal areas were tidy and had been dusted and hovered and most bathroom fittings had been cleaned. The premises smelt fresh. Cleaning schedules were introduced during our inspection. However, in kitchen cupboards there were loose open packs of flour that should have been in sealed containers to prevent infestation. One person's bathroom was dirty and their toilet stained with faeces. Staff told us the person needed assistance to keep their room clean. No soap or paper towels were provided in the first floor bathroom for handwashing after people had used the shared toilet on the first floor. There was a tear in the bathroom floor covering, which could harbour germs and be difficult to clean effectively.

The infection control policy written in January 2015 did not adhere to the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. For example, it did not address the control of outbreaks of certain infections, how to manage contact with blood or body fluids other than reporting to a manager, or the dress code for staff.

These shortfalls a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people and staff were not protected against identifiable risks of acquiring an infection.

Requires Improvement

Is the service effective?

Our findings

Staff received basic training to help ensure they had the skills and knowledge required to perform their roles. This was up to date and included a range of topics such as first aid, fire, food hygiene, safeguarding, infection control, and medicines. Staff had also been assessed as competent to handle medicines. Epilepsy awareness was included with the first aid training. These topics had been incorporated within the induction training for a recently recruited member of staff. Training was reflected on the staff training plan, which showed when staff were due to undertake refresher training. However, despite the nominated individual visiting and spending time supporting people, they were not included in the training plan and record.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as information about a staff member was not included with the information used by the manager to plan for staff training.

Staff had opportunities for informal telephone support from the nominated individual. One staff member said they had found this very supportive.

However, supervision sessions, where staff met with their line manager to discuss their work and any concerns they had about it, did not happen regularly. This contravened the provider's supervision policy, which required that care staff had at least one hour's formal supervision every two months. One staff member, who had worked at Helene Lodge throughout 2014, had only two supervision records on file: one in July that stated supervision could not be done on that date and another in September. There were no supervision records on the other two staff files, although one of these staff had joined very recently. The other staff member said they were due to have their first supervision session; they had been in post over two months.

The shortfall in supervision was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as some staff had not been supported in their roles through the supervision process.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. Providers are required to apply to a 'supervisory body' for authority to deprive people of their liberty. The provider was aware of a Supreme Court Judgement in 2014 that widened and clarified the definition of a deprivation of liberty and had made applications for four people. Two of these applications were awaiting assessment and two had been approved, one with the condition that the person had 'more 1:1 time' with staff. Whilst the person had one to one time on an ad hoc basis or occasional planned trips out with a manager, one to one staffing was not routinely allocated. We drew this to the attention of the supervisory body, who afterwards reviewed the person's deprivation of liberty and confirmed the condition was met in view of arrangements made following the inspection for increased staffing.

Where people lacked the mental capacity to make decisions about aspects of their care and support, staff were guided by the principles of the Mental Capacity Act 2005 to ensure that any decisions were made in the person's best interests. Staff had received training in the Mental Capacity Act including DoLS. Mental capacity assessments and best interest decisions were in place for people's care and support. They were also in place for certain other matters, such as managing finances, if people were unable to make these decisions for themselves. Some, but not all, people had best interest decisions in place for taking medicines. Staff told us that people took their medicines and the current medicines administration records contained no records of refusal.

We recommend that the provider reviews their arrangements for documenting people's consent to, or mental capacity assessments and best interest decisions in relation to, medicines.

People were supported to have enough to eat and drink and to maintain a balanced diet. They told us they had a choice of food and were encouraged to eat healthily. One person said they were going to try and eat more salad as their doctor had recently advised them to keep an eye on their weight. There was a well-stocked fruit bowl in the kitchen and healthy food in the fridge. A three week rolling menu was displayed in the kitchen and this contained alternative items for particular individuals according to their preferences and needs. One person told staff they did

Is the service effective?

not fancy the meal on offer that night and the staff member supported them to decide what they would like to eat instead. People requested drinks and staff encouraged and supported them to prepare these.

Staff monitored people's weights monthly but not their body mass index. No malnutrition tool, such as the Malnutrition Universal Screening Tool, was used to identify unplanned weight changes and give guidance about how to manage these.

We recommend that the service reviews their system for identifying and managing the risk of malnutrition, including adopting a recognised malnutrition screening tool for use in care settings.

One person had some difficulty with swallowing. A speech and language therapist had assessed this in 2014 and had provided a safe swallow plan to guide staff in how to support them safely with their food. Staff said the person understood what sorts of foods they were able to eat and to say if something caused them difficulty.

People were supported to maintain their health. Their records showed they had annual health checks at the GP surgery; this is a national initiative for people with learning disabilities. They also had access to other age and gender-appropriate health screening and dental appointments. They saw GPs, psychiatrists and other health professionals when they were unwell or to monitor long term health conditions.

Good

Is the service caring?

Our findings

People told us they liked the staff. A relative commented that their family member was happy living at Helene Lodge and gladly returned there after staying with them. We observed people approaching staff to speak with them, and staff interacted with them calmly, respectfully and warmly. Staff listened to people, allowing them time to express what they wanted to say and not rushing them. When we first arrived for the inspection, one person was anxious about being ready in time for their day centre transport and the staff member reassured them.

All of the staff, even the person who had very recently started working at Helene Lodge, were able to tell us about people's needs and preferences. They spoke about people in a respectful way.

People said they were able to make choices and that staff respected these. For example, one person said they got to choose what to wear and that they normally got a choice about meals. Whilst care plans contained little evidence of people's and families' involvement, staff told us how they supported people to make decisions regarding their care. For example, the nominated individual explained that one person had decided they no longer wished to attend day centre. This person had 1:1 time with staff during the day and chose what activity they wanted each day. The nominated individual had organised a short break with another person, at a place that reflected the person's interests. Staff said that two people in particular often asked to see their care plans.

There was little information in communal areas about local facilities and forthcoming events that might be of interest to people at Helene Lodge, to support them to make choices about how to spend their time. This is an area for improvement.

One person told us they sometimes helped with cooking meals, and that staff helped them clean their room. Staff and managers confirmed they encouraged people to be involved with household tasks and to do things for themselves, with staff support where needed. They acknowledged that this could be difficult to do with only one member of staff on duty.

People's privacy and dignity were respected. Each person had their own bedroom and staff checked with them that they were happy for us, and the maintenance person and heating engineer, to see their rooms. All bedrooms reflected the person's own tastes, with their pictures, posters and other personal items on display. People were dressed neatly and cleanly and had the opportunity to see a visiting hairdresser; some had haircuts during the inspection.

People were supported to keep in regular contact with their families. During the inspection a person was supported to visit a relative who was unwell. Someone else used the phone to speak with a family member and staff supported them to have privacy for their conversation. Relatives told us their visiting was not restricted.

Requires Improvement

Is the service responsive?

Our findings

People told us they liked Helene Lodge. One person said they were able to pursue their hobby of baking every weekend. They also told us that staff had fixed up for them to go horse riding every so often, as this was also something they enjoyed. Someone else told us about their enjoyment of theme parks and about their planned short break away to a theme park with a member of staff. Most relatives were broadly positive about the way their loved one was supported. However, records indicated flaws within the care planning process.

Care plans were not all sufficiently detailed for staff to be sure about how to support people. For example, one person's health care plan instructed staff to make the person comfortable following a seizure but did not explain what this meant. The person had an epilepsy care plan devised by a specialist health care professional but this was kept separately and could have been difficult for new staff to find in an emergency. Another person's care plan mentioned a specific mental health condition without explaining what the condition meant for this person, other than they might talk to themselves or suddenly change topics of conversation. It did not give any indication of the person's views about their mental health. Information about the condition was not available for staff who might not have knowledge or understanding about it.

Where health professionals had assessed and advised on aspects of people's care, this advice was not always reflected in care plans and risk assessments. Consequently, there was a risk that staff who were not familiar with people's needs, such as agency staff, would not be aware of how to support people safely. A speech and language therapist had assessed one person's swallowing difficulties in 2014 and had devised a safe swallow plan. This set out the support the person needed to reduce the risk of choking. The person's nutrition care plan made no reference to the safe swallow plan, although it did mention the person may struggle to chew dense food. It did not make clear the risk of choking on certain foods or that the person needed supervision when eating, even though the safe swallow plan highlighted this. There was no risk assessment for eating and drinking. However, all the staff we spoke with were familiar with the person's support needs as regards eating and drinking and pointed out that the person had good awareness of foods that could cause them difficulty.

Care plans had not been reviewed since they were written some months before, in one case going back to April 2014. Without regular review, staff could not be sure that people's needs were being met effectively. There was a risk that care plans did not reflect people's current needs and so unfamiliar staff would not know how best to support them and ensure their safety. For example, one person had very recently started to use a falls alarm, but their care plan had not been updated to reflect this. Their health care plan stated they were unsteady on their feet but had not been reviewed following subsequent falls that were documented on incident forms. Another person's health care plan did not reflect health concerns that had recently led to investigations in hospital.

Similarly, people's risk assessments had not been reviewed and updated on a regular basis or in response to accidents or incidents. This meant staff might not have been aware of particular threats to the person's safety and wellbeing and how best to manage these. One person's risk assessments, written in 2011 when Helene Lodge was owned by a different provider, had last been updated in 2013. The person's file also contained blank risk assessment proformas that had not been completed.

Arrangements were not in place to support people to meet their social needs. Care plans mentioned social and leisure needs, but had little information about people's friendships and people who were special to them other than their families. Whilst people were supported to keep in contact with their families, they had few opportunities to pursue friendships other than through day centres. One person's care plan mentioned particular social groups they enjoyed at weekends, but their care records for January 2015 showed they had not attended these. Staff said they thought people used to go out in the evenings and at the weekends but that this had stopped happening.

These shortfalls were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(1) and 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the planning and delivery of care and support did not meet people's individual needs or ensure their safety and welfare.

Requires Improvement

Is the service responsive?

Care plans covered the main areas of support people needed, but did not reflect people's own goals and what was important to them, or the involvement of their circle of support, their relatives and other people involved with their support. Relatives told us of varying degrees of involvement in planning their loved one's care. One relative said they were as involved as they wished to be. Another indicated they were not really consulted, and a further relative said they were very involved.

We recommend that the provider reviews the approach to care planning, to ensure that this involves people and their circle of support in planning and reviewing care, as appropriate.

The service was unable to demonstrate learning from complaints and lacked a system for learning from people's or relatives' comments or concerns. Local authority information on how to make a complaint was displayed prominently in the hallway. This was written in an easy-to-read format, with photographs. According to the provider's complaints records, there had been one complaint in the past six months. There was a record of a discussion with the complainant about what would happen, but the action taken, feedback to the complainant and any learning or changes in practice had not been documented. Relatives told us there were occasions when they had voiced concerns but these were not treated as complaints or opportunities for learning, although contact with relatives was recorded in people's files.

The shortfall in learning from complaints and comments or concerns was a breach of Regulation 10(1) and 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not have regard to people's or their representatives' complaints and comments in monitoring the quality of the service and managing risks.

The shortfall in recording complaints was a breach of Regulation 20(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not protected against the risks of unsafe or inappropriate support by means of maintaining up-to-date records in relation to the management of the service.

Inadequate

Is the service well-led?

Our findings

People had lived alongside each other at Helene Lodge for a number of years. Relatives commented that their family members had had to adjust to changes when the current provider took over in 2013. This involved a completely new staff team, which had changed further since the provider acquired the home, and changes in the culture of the service. When asked about the culture at Helene Lodge, staff members talked about people being supportive of and understanding towards each other. Communal areas of the house looked functional rather than homely, with empty shelves and few pictures or posters on the walls. There was little evidence of strong links with the local community, with no information about local organisations and events on display or to hand in communal areas.

At our last inspection in April 2014 we found the provider did not have an effective system to regularly assess and monitor the quality of the service, nor to identify, assess and manage risks to people's health, safety and welfare. People had not been adequately protected against the risk of fire. There was no legionella risk assessment or management plan in place. Actions from monthly management audits were not followed up. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan stating they would improve their quality assurance and risk management system to meet Regulation 10 by 20 July 2014. However, this was later revised to November 2014 to allow for the installation of a fire detection and warning system by the deadline set by the local fire and rescue service.

At this inspection in January 2015 we, there were continuing shortfalls in the provider's quality assurance and risk management systems. The failure to implement an effective system to assess and monitor the quality of the service had meant that they had not identified the breaches of the regulations relating to the care and welfare of people, safeguarding, infection control and prevention, medicines management, the safety of the premises, staff training and records that we found at this inspection.

In addition, there were repeated breaches of the regulations relating to staffing levels, and to quality assurance. This showed the provider had failed to have regard to our last inspection report.

Risks to people's health safety and welfare were not all identified or acted upon. For example, staff had recorded daily hot water temperatures at some taps in excess of 60oC since November 2014, which put people at risk of scalds. The form stated that temperatures more than one or two degrees above or below 43oC should be reported to the home manager. This had been noted in the maintenance file and a 'management and risk report' at the end of December 2014. The provider was not aware of the high water temperatures and action had not been taken to ensure they were in the safe range. Following the inspection, the provider informed us they had arranged for water temperature regulators to be fitted to hot taps. Additionally, the fire extinguisher mentioned in our last report that did not bear a sticker showing when it had last been serviced was still there, with no sticker.

There had been delays in attending to other hazards and breakages identified in maintenance checks, which remained outstanding. These included a broken light over the upstairs bathroom sink that had been logged in June 2014. A note dated November 2014 stated that an electrician was needed. The light was still broken. Some hazards and maintenance issues had not been identified at all in health and safety checks, such as torn flooring in a bathroom, faulty kitchen spotlights, bulbs that had blown in the lounge ceiling light and an unrestricted window opening in the upstairs bathroom. The provider informed us they had experienced difficulty in finding reliable maintenance people.

An audit of people's finances in November 2014 was not robust. It stated all monies were correct and receipts in good order, and identified no action to be taken. However, we saw envelopes of receipts in the office drawer dating back to April 2014. The home manager acknowledged the receipts should have been checked and filed on people's cash sheets, as the provider's service user finance policy stated.

Information from quality assurance surveys, incidents and compliments, comments and complaints was not used to improve the quality of the service. Quality assurance surveys had been completed by staff and families in summer 2014. There was no action plan arising from this

and adverse comments had not been followed up. Some family members described continuing issues with communication, which suggested these had not all been addressed. Incident forms contained no evidence of review by managers, or of any learning and improvements in response to incidents; they were not designed to require this.

There was no regular, documented method of obtaining people's feedback about the service and using this to develop the service. Only one house meeting had been recorded since our last inspection; this had addressed issues raised by staff rather than obtaining people's views. The nominated individual said people's feedback was sought informally, rather than at house meetings, but this was not recorded.

Similarly, there was no regular system to obtain feedback from staff other than through annual quality assurance surveys and supervision, which did not happen regularly. The nominated individual informed us they and the home manager regularly supported staff through informal face-to-face and telephone conversations. Staff described managers as supportive to talk with. However, concerns regarding lone working raised by staff in supervision and via the staff communication book had not been acted upon. The manager's supervision record stated that staffing would be increased during personal care routines and at weekends. This had not happened.

These shortfalls in quality assurance and monitoring were a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not protected against the risks of unsafe or inappropriate care by means of effective quality assurance and risk management systems.

Some records relating to people's care and to the management of the service were incomplete. For example, staff had recorded they had asked managers to make contact with a person's relative at the relative's request, but no subsequent contact was documented. A behaviour record chart and social diary on a person's file were not dated to show when particular incidents and events had occurred.

Records for two managers who had regular contact with people were not readily available. We were shown one of these files when we returned on 6 February 2015 to give feedback. The staff member had transferred from one of the provider's other services over two months before but their file had been retained at their previous workplace. Their recruitment records related to their recruitment to their previous role and did not contain details of their transfer to their current post. The other staff member was the nominated individual, who supported people regularly and did so during the inspection. Additionally, the nominated individual was not recorded on the staff training plan.

Records were not kept securely. People's care records were stored on open shelving in an office with an unlocked door and which was not always attended. In addition, although staff files were locked away, some staff personal information was available in some of the management files, which were also stored on the open shelving.

The shortfalls in recording were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not protected against the risks of unsafe or inappropriate care arising from a lack of proper information in up to date, securely stored records.

There had been no registered manager since July 2014. The current home manager, who had been in post two and a half months, had not yet applied to register. The provider informed us they were expecting this manager to apply and we saw records that showed they had been expected to do so by 31 January 2015. Managers had submitted notifications about important events, which the service is required to send us by law, with the exception of an event that had happened the week before the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 How the regulation was not being met: People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Care was not planned and delivered in such a way as to meet people's individual needs or ensure their welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who use services were not safeguarded against the risk of abuse by means of reasonable steps to identify the possibility of abuse and prevent it before it occurs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against identifiable risks of acquiring infections by means of the effective operation of infection control and prevention systems and the maintenance of appropriate standards of cleanliness and hygiene.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the safe keeping of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because these had not been maintained adequately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Records about their care and treatment were not maintained accurately. Staff records and other records about the management of the regulated activity were not all up to date or readily available. Records were not all kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not have suitable arrangements in place to ensure staff were appropriately supported in relation to their responsibilities, by receiving appropriate supervision.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care, by means of effective systems for quality assurance and risk management.

The enforcement action we took:
We issued a warning notice for continuing breaches of the regulation to be met by 31 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed.

The enforcement action we took:
We issued a warning notice for continuing breaches of the regulation to be met by 31 May 2015.