Dr Azim D Lakhani & Mr Amin Lakhani & Mrs Malek D Lakhani

Bonhomie House

Inspection report

Dodwell Lane
Bursledon
Southampton
Hampshire
SO31 1DJ

Tel: 02380402168
Website: www.saffronlandhomes.com

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20, 21,22 and 31 March 2017 and was unannounced

Bonhomie House is a nursing home which provides care and support for up to 78 people living with a wide range of complex healthcare needs. These include acquired brain injuries, neurological conditions, physical disabilities and mental health issues. At the time of our inspection there were 70 people living at the service. Bonhomie House provides a range of accommodation. The main house is spread over three floors. The people living in the main house receive a mixture of one to one and shared care provided by a team of nursing and care staff. Also on site are a number of both shared and single dwelling bungalows where people receive either shared care or one to one support. The service has an activity hall with a swimming pool and Jacuzzi which can be used for therapeutic and leisure activities.
At the last inspection in January 2016, we rated the service as requires improvement and found breaches of three Regulations. An action plan was submitted which identified the steps that would be taken to address the breaches of the Regulation. This inspection was to check whether the service was now compliant with the Regulations.

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

Issues identified at the last inspection relating to how risks to people were assessed and managed had not been adequately addressed. We have identified a continuing breach of the Regulations with regards to this.

Improvements had been made to ensure that following incidents involving people and aspects of their care, remedial actions were taken to reduce any ongoing risks. However, the investigations were not always well documented and one incident of concern had not been escalated to the relevant authorities.

Staff were having more frequent supervision and appraisals, although we have made a recommendation about how the provider should ensure supervision is provided in line with best practice guidance.

Sufficient improvements had been made to the management of people's medicines. The service was generally clean.

We did however identify new breaches of the regulations.

There were insufficient staff deployed to meet people's needs. The provider was continuing to recruit new staff but there remained a high use of agency staff, some of whom people found it difficult to communicate with. People told us this sometimes had a negative impact on their care.

Records relating to assessment and care planning were not consistently completed to a good standard. Care plans were not always accurate and fully reflective of people's needs or of the care delivered. We could not be confident that there were effective arrangements in place to seek and act on feedback from people, their relatives and staff.

Whilst we were able to see that some improvements had been made since our inspection many of these systems were still in their infancy or needed to be further developed in order to bring about lasting improvements and support the management functions of the home.

An activities programme was in place but some people and professionals told us more still needed to be ensure people had access to a meaningful and varied programme of activity and engagement that helped to improve their wellbeing. We have made a recommendation about this.

Improvements were needed to ensure that staff had all of the training relevant to their role. We have made a recommendation about this.

Whilst staff demonstrated a good understanding of the Mental Capacity Act 2005, not everyone who needed an assessment of their mental capacity to make decisions about their care, had one in place. Best interest's consultations needed to be more clearly documented. Applications for deprivation of liberty safeguards had been appropriately submitted.

People were provided with adequate food and fluids and were able to choose from a range of suitable meals. Staff were attentive to people and assisted them to eat and drink in a person centred manner. However, we felt that some aspects of the dining experience could be improved.

Whilst a complaints procedure was in place, this was not displayed anywhere within the service. The complaints that had been received had been responded to.

People told us that staff were kind and caring. We observed a number of positive and warm interactions between people and staff and staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

We identified one continuing breach and two new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the end of this 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 continued to be rated as requires improvement.

Improvements were still needed to ensure that all risks to people's health and safety were effectively assessed and planned for.

Improvements had been made to ensure that following incidents involving people and aspects of their care, remedial actions were taken to reduce any ongoing risks. However, the investigations were not always well documented and one incident of concern had not been escalated to the relevant authorities.

Sufficient improvements had been made to the management of people's medicines. The service was generally clean.

There were insufficient staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service continued to be rated as requires improvement.

Staff were having more frequent supervision and appraisals, although not always in line with best practice guidance. Improvements were needed to ensure that staff had all of the training relevant to their role.

Whilst staff demonstrated a good understanding of the Mental Capacity Act 2005, not everyone who needed an assessment of their mental capacity to make decisions about their care had one in place.

Improvements were needed to ensure that staff always responded appropriately and in good time to people's changing health care needs.

People were provided with adequate food and fluids and were able to choose from a range of suitable meals. Staff were attentive to people and assisted them to eat and drink in a person centred manner. However, we felt that the dining experience could be improved.

Is the service caring?

Good

The service continued to be rated as good.

People told us that staff were kind and caring. We observed a number of positive and warm interactions between people and staff. Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

Is the service responsive?

Requires Improvement

The service continued to be rated as requires improvement.

Records relating to assessment and care planning were not consistently completed to a good standard. Care plans were not always accurate and fully reflective of people's needs or of the care delivered.

An activities programme was in place but more still needed to be done to ensure people had access to a meaningful and varied programme of activity and engagement that helped to improve their wellbeing.

People told us their views were not always listened to. Whilst a complaints procedure was in place, this was not displayed anywhere within the service. The complaints that had been received had been responded to.

Is the service well-led?

Requires Improvement

The service continued to be rated as requires improvement.

Communication within the service was not always good and there was scope for greater consultation with people about their views on the quality of the care provided.

Quality assurance systems were in place, but these were not yet being fully effective at driving improvements.

Whilst we were able to see that some improvements had been made since our inspection many of these systems were still in their infancy or needed to be further developed in order to bring about lasting improvements and support the management functions of the home.

Bonhomie House

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.

The inspection took place on the 20, 21, 22 and 31 March 2017 and was unannounced. On the first day, the inspection team consisted of two inspectors, a specialist advisor and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used a service similar to Bonhomie House. On the second and last day there was one inspector and on the third day, two inspectors and a medicines inspector:

Prior to this inspection we had received a number of concerns about the care people received at this service. This information was shared with the local authority and with the local clinical commissioning group. The concerns are being investigated and the service is also being supported under a quality improvement framework led by the local authority. Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the manager tells us about important issues and events which have happened at the service. We asked the provider to complete a provider information return. 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 used all of this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 27 people who used the service. We also spent time observing aspects of the care and support being delivered. We spoke with the general manager, the deputy manager, two assistant managers, the chef and 17 nursing and care staff, some of whom were permanent staff and some agency workers. We also spoke with ten health and social care professionals and asked their views about the care provided at Bonhomie House.

We reviewed the care records of ten people in detail. We also reviewed the recruitment records of six staff and the training and supervision records of a further six staff. We also looked at other records relating to the management of the service such as audits, incidents, policies and staff rotas.

The service was last inspected in January 2016. At that inspection, we found three breaches of the legal requirements.

Requires Improvement

Is the service safe?

Our findings

Many of the people living at Bonhomie House were doing so because they had experienced a catastrophic brain injury or an event which had led them to develop complex healthcare needs. Others were living with chronic mental health problems. At times, this affected how positive they felt about their care and about living at the service. However, they all told us that they did feel safe living at Bonhomie. One person said, "I have lived here for ages and ages and I feel safe here….The staff know how to transfer me and always wear gloves and aprons". Another person said, "It's my home…I feel very safe here".

Whilst people felt safe living at the service, we found that some improvements were required. Our last inspection had found that risks to people's health and wellbeing were not always effectively assessed and planned for. This inspection found that the quality and consistency of risk assessment and risk management remained an area of concern. For example, one person was noted to be at risk of self-harm. Their care plan stated that there should be a ligature cutter readily available. This was not the case. One person's care plans gave conflicting advice about how their eating and drinking risks should be managed. This could place the person at risk of receiving inappropriate foods. Where people had been assessed as being at risk of poor nutrition, tools used to monitor this were not always being consistently used. People were not always being weighed on a regular basis. One person was prescribed a thickening powder to help reduce their chances of choking when swallowing liquids. Once the containers had been opened these were stored in this person's room, but there was no risk assessment about this in this person's care plan. It had been arranged for one person to have one to one observation due to potential risks they could present to other female service users. We twice found this person unaccompanied. Following falls, the provider's post falls protocol was not being consistently used to assess risks to the person and to monitor their wellbeing. We spoke with an agency registered nurse who had English as a second language. They were unable to comprehend our questions about the care required by one person. They had been working at the service for some time, but were not able to tell us about the emergency response this person would require in the event of having a seizure. We were concerned that this could compromise their clinical care.

It was not always evident that action was being taken to address environmental risks. For example, it was not clear what actions had been taken in response to hot water checks being found in excess of safe limits in January 2017. A fire risk assessment had been completed in January 2016. The recommended actions had not been signed off as being completed. Since the inspection, the provider has sent us records which state that action has been taken to address both of the above matters but it was not clear why this had not been done earlier. Audits were undertaken of the call bell system. These showed that some of the call bells had not been working since November 2016. We were concerned that people would not be able to summon assistance should they need this. The registered manager has now confirmed that these have all been repaired. Checks to demonstrate that staff were complying with food hygiene requirements had not been taking place at weekends for some months. The chef told us this was due to agency staff overseeing the kitchen at weekends. People had personal emergency evacuation plans which detailed the assistance they would require for safe evacuation of their home and a business continuity plan was in place which set out how the needs of people would be met in the event of an emergency such as a fire or flood. Our last inspection report had highlighted that this did not contain details of how the service would manage a

situation in which the home became uninhabitable. The provider told us that arrangements would be made to accommodate people at its other local homes. We were concerned that this could be challenging due to the large number of service users and their complex needs. This remained a concern.

The above evidence is a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe care and treatment.

Other risks were well managed. People at risk of choking had been identified and care plans were in place. We observed a number of people being assisted to eat and drink and this was provided in a safe manner. Upon questioning, staff were able to demonstrate an understanding of how to identify and respond to an incident of choking. People had individualised catheter care plans. People with skin damage or pressure ulcers had their wounds and dressings checked regularly. There was evidence that the tissue viability nurse had been consulted where necessary. People's skin integrity was discussed at each handover.

Checks were made of the fire protection systems and detection equipment. These were up to date and most staff were trained in fire safety. Fire drills took place periodically. There were current certificates confirming the safety of the lift and of the gas and electrical items within the service.
At our last inspection, we had found that incidents and accidents were not being reviewed robustly or that action had been taken to consistently escalate potential safeguarding concerns to the relevant agencies. This inspection found that some improvements had been made. There was evidence that the registered manager or deputy reviewed the incidents that had taken place to assist in identifying any themes or trends. In response some remedial actions were being taken to prevent similar incidents from happening again. For example, in December 2016, there had been a number of incidents of behaviour which might challenge others involving a specific person. As a follow up, bite size, internal mental health training had been provided. An accident trend analysis was completed each month which looked at the type of accident, the time it occurred and the location. After reviewing the accidents from January 2017 a person was referred to the physiotherapist due to their increased number of falls post hospitalisation. A falls register was now being kept and a post falls 'huddle' used to reflect on what might have been the cause of the fall and plan actions that might decrease the risk of future falls.

Some incidents were still not always responded to appropriately. For example, we saw an incident form which reported that a person had hit and kicked another person. The incident had been reviewed by a senior staff member but had not been escalated to the local authority. The registered manager has now done this. Further improvements are therefore needed to embed and sustain a culture of positive reporting, carrying out robust investigations and using this to develop staff practice and learn and make lasting improvements.

We looked at the staffing arrangements within the home. Day shifts were currently staffed by between 33 and 36 care workers. At night there were 20 care workers. The number of care staff required was based upon the assessed needs of people using the service which in many cases was determined by the organisation funding or commissioning the person's care. The provider's staffing plan stated that their aim was to have three registered nurses on duty during the day, two within the main house and one overseeing the care of people living in the bungalows. There were three nurses at night. Staff rotas showed that the target staffing levels described above were usually being met.

During the inspection our observations indicated that people's needs were being met appropriately, however, people told us this was not always the case. A number of people living in the main house told us there were not always sufficient staff deployed to meet their needs in a timely and person centred manner. We asked them how this impacted on them. One person said, "They change your pad too quick". Another

person told us they sometimes had to wait ten to thirty minutes for attention. A third person said, "A couple of weeks ago, I had a wet pad and trousers, instead of coming to help me, they continuously reset the alarm". This person told us they had been waiting for over an hour for support. They did advise that this length of time was more the exception rather than the rule". This person and others felt that staff were trying to do the best they could, but that there was just not enough of them". A fifth person said, "My personal care is often done late and I am still in bed when my son arrives to take me out". A sixth person said, "It takes the staff a long time to answer the call bell. They come in and switch it off and don't come back. When staff are in a meeting they don't come at all". The registered manager was not currently able to monitor staff response to people's call bells as the system in place did not facilitate this.

Staff gave us mixed feedback about whether there was always enough staff. Generally staff working in the bungalows felt there were enough staff. They told us staffing levels here were prioritised above the main house. Staff in the main house were less positive. One care worker said, "Sometimes, yes there are enough staff, sometimes, no. However, the residents are our priority, we pull together, all the personal care and eating and drinking needs to be done". Another staff member told us there were not enough staff. They said, "We get moaned at because nails are dirty, but we don't have time to do the extras".

Most of the health and social care professionals we spoke with expressed concerns about how staff were deployed within the service. A social care professional told us they had visited to find a person alone in their flat with their lunch. This person's care plan stated they should be supervised when eating. They were concerned that this could have placed this person at risk of harm. They told us, they were increasing the frequency of their visits to the service as they were concerned for people's care. They said, "It's always really difficult to find a free member of staff…I'm often waiting outside for 20 minutes for someone to answer the door, often it's a resident who lets me in". Another professional told us, "I have noted on occasions, the difficulty some staff have trying to be relieved for breaks from one to one [support]". A third professional said, "The individual care staff do a great job, they don't get a lot of support, but do their best, they are pulled from pillar to post". This was echoed by a fourth professional who told us, "The staff are upbeat, but I suspect there isn't enough of them and whilst they are caring, it is difficult to be positive all of the time".

When we last inspected, the service had 19 staff vacancies. This number had now increased to 33. There were currently also four vacancies for registered nurses. The provider was actively working with recruitment agencies to employ new staff and was in the process of recruiting nine new care workers but checks were still ongoing and so they had not yet started. In the meantime, agency staff were being used to cover gaps in the rota. Rotas showed that regular agency staff were being used to cover gaps in the rota where able, but this was not always possible and we did, for example, see that recently there had been a Saturday when all of the registered nurses on duty were agency nurses. Two of the agency nurses had not worked at the service before. We were concerned that this could impact on their ability to safely oversee the care of people with such complex physical and mental health needs, particularly in the absence of the management team, although they were available on an on call basis.

There were insufficient numbers of staff deployed to meet people's needs at all time. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Relevant recruitment checks had been completed. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. Staff underwent a competency based interview which tested their skills and knowledge in relation to areas such as safeguarding people from harm.

Overall we found the service was clean and free from malodours. A number of new chairs had been purchased that were easy to wash and keep hygienic and clean. Staff were seen to be using personal

protective equipment such as plastic aprons and gloves effectively. However some improvements were needed. We noted that some of the equipment used for supporting people with moving and transferring was dirty. Some people's wheelchair cushions were dirty and a number of bed rail bumpers were worn and in need of repair. This had also been a concern during our last inspection. The provider's policy stated that when carrying out personal care or nursing tasks, sleeves must be rolled up above the elbow, or short sleeved work wear worn, but we saw a registered nurse wearing a hoody underneath their uniform. A number of staff were wearing jewellery such as bracelets which was again not in line with the provider's policy as it can increase the risk of people being injured during moving and handling tasks. Cleaning schedules were in place and an infection control audit had been completed by in January 2017. People provided positive feedback about the cleaning staff.

During our last inspection we identified concerns in relation to how medicines were managed and disposed of. This inspection found that the required improvements had been made. We watched some medicines being given to people at lunchtime, and saw that these were given in a safe way. People were asked if they needed any medicines that had been prescribed for them on a 'when required' basis, for example pain relief. There was no-one who looked after all of their own medicines at the time of this inspection. However there were policies in place to allow this if it was suitable and had been assessed as safe for them to do this.

Charts were completed when medicines were given, or reasons recorded if doses were omitted. These records showed that people received their medicines in the way prescribed for them. However at the time of the inspection we saw a gap in two people's records where the charts had not yet been signed, but the medicines had been given at the correct times. Records were kept of medicines received into the home and those sent for disposal, which helped to check how medicines were managed in the home.

Care plans had information about people's medicines and how and when these should be administered. There were separate recording sheets and protocols for medicines prescribed 'when needed', and times were recorded when doses were given. Some of these charts did not contain detailed personalised information to guide staff on when it would be appropriate to give a dose, however there was further information available for staff in people's care plans. We did note that some people had their medicines crushed or mixed with food, but the pharmacist had not been consulted to check that this was safe to give these specific medicines in this way.

Medicines were stored securely in locked rooms and cupboards, and temperatures were monitored to make sure medicines were stored at the correct temperature so that they would be safe and effective. There were suitable arrangements for storing and recording medicines requiring extra security. There had been improvements to the systems for disposal of medicines and there were now appropriate measures in place. Monthly medicines audits were completed, which had picked up some minor issues which had been dealt with. However some issues with the recording of external preparations had not been picked up. There was a system for reporting any medicines errors and incidents, and any actions taken were recorded.

Staff had received training in safeguarding adults, and understood the signs of abuse and neglect. The care staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. For example, one staff member said, "I would report any concern to the manager straight away." Staff were also aware of how to report concerns about poor practice which is often known as whistleblowing. One staff member told us, "If I was not sure [a concern] had been reported properly I would contact social services or CQC myself and raise it."

Requires Improvement

Is the service effective?

Our findings

Overall people told us they received effective care. People were positive about their regular care workers. One person said, "Yes they [the care workers] are well trained, they know what they are doing". Another person said, "They [care workers] have done wonders, I'm a lot better than when I came….it's really marvellous". A third person told us staff were "Generally trained to a pretty high level". People told us they would recommend the service to others. Their comments included, "I would recommend someone to live here because it is safe" and "I would recommend someone to live here as I am cared for". However, people told us their support was less effective when this was provided by staff they did not know or by unfamiliar agency staff. One person said, "They are short staffed at the moment, they are using lots of agency staff, they need briefing and training and it slows things down". A relative said, "[The person] is not progressing as there are too many strange faces daily". Another relative said, "I would like the same carers more, we don't know any of them, [the person] can lash out, it's not easy for new carers to manage". This was echoed by a third relative who said, "Every time I go it's a different lady, I've never seen the same one twice". A healthcare professional said, "The home can be chaotic at times, there is a reliance on bank / agency staff". Another healthcare professional said, "It is imperative that continuity of care is maintained and this I believe has not always been the case because of the rapid turnover of nursing staff and mangers".

Some people expressed concerns about some staff not being able to effectively communicate in English. They felt this at times impacted upon the effectiveness of their care. One person told us, "The staff work very hard but I have problems communicating with the foreign workers". Another person said, "I can't understand the foreign workers and they don't understand me. It can make things difficult ". A third person said, "I sometimes have difficulty understanding what staff are saying to me as they don't speak English". The provider told us the recruitment of new staff included an assessment of their understanding of English. They said staff were encouraged to develop their spoken and written skills and were provided with additional support to do this where necessary. Where agency staff did not display a suitable command of English, the provider told us they would not book the member of staff again until they were able to demonstrate they were able to communicate effectively in English.

We looked at how staff were supported and provided with opportunities to develop their skills. When new staff started at the service, they undertook a 'First Day at Work Induction'. This involved an explanation of their role and responsibilities, a tour of the building and other practice information and advice. Staff then had an opportunity to shadow more experienced staff for a week or so. The provider was not however, able to demonstrate that staff were completing the care certificate. We asked for records relating to this, but the management team were unable to provide this. This was also a concern at our last inspection. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. The Care Certificate is recognised as the minimum training which must be completed and assessed, before staff new to a caring role practice without direct supervision. The provider was not able to demonstrate that any staff who had started at the service within the last 12 months had completed the Care Certificate. A number of staff told us they were still working toward the skills set out in the Care Certificate. For example, one care worker who had been employed for over a year told us they had only completed one workbook.

Our last inspection found that the provider had not ensured that staff were receiving appropriate supervision and appraisals. Supervision and appraisals are important tools which help to ensure staff remain suitably skilled and understood their role and responsibilities. This inspection found that some improvements had been made. Most staff had received an annual appraisal. Records showed that the frequency of supervision had also improved for some but not all staff. We had some concerns about the quality and nature of the supervision that was taking place. This was because the majority of staff we spoke with told us they were not receiving supervision, however the provider's records indicated that they were. Best practice guidance issued by Skills for Care states that 'about one to one-and-a-half hours is recommended for a formal supervision session, especially in a busy residential care or nursing home'. It recommends that these meetings should be private and free of interruption'. The assistant manager told us that the supervision provided was a mixture between private one to one sessions and group observations. For example, the assistant manager had undertaken some basic observations of staff during the lunchtime service. However the provider's supervision records, did not distinguish between the type of supervision provided and so we were unable to be confident that staff were having a suitable combination of observational and formal one to one sessions.
Overall though staff told us they felt supported and able to seek advice and support from more experienced members of staff.

We recommend that the provider review the arrangements within the service for supervision and ensure these are in line with their policies and procedures and in keeping with best practice guidance.

Training records did not provide a readily accessible and accurate overview of the all of the training undertaken and when this was next due. Whilst a training matrix was being developed, most of the training records were kept in staffs' individual files. This was not an effective way to monitor the training requirements of staff and meant that the registered manager could not be confident that staff had all of the training required. Following the inspection, we were sent an updated training matrix. This showed that staff had training in 'five essentials' which were refreshed annually and included safeguarding, health and safety, infection control, basic first aid and food hygiene. Staff also undertook annual training in moving and handling and fire safety. This training was mostly up to date. The matrix showed that some staff had completed additional training relevant to the needs of people using the service. For example, 25 of the 43 care and nursing staff employed had completed training in managing behaviour which challenges others and 29 staff had completed training on the Mental Capacity Act (MCA) 2005. Approximately one third of staff had completed training in caring for people living with dementia and other subjects such equality and diversity and end of life care. Seven staff had been trained in person centred care. During the inspection, some staff completed dysphagia training delivered by a healthcare professional. Dysphagia is the medical term for difficulty with, or discomfort when swallowing. A healthcare professional had also previously delivered training in wound care. There were plans for staff to have additional training allowing them to become champions in areas such as diabetes and infection control. It was planned that they could then act as a role model to the wider staff team.

Arrangements were underway to provide staff with basic mental health awareness training and on managing behaviour which might challenge others. However, many of the people using the service were living with very complex mental health conditions and some of the staff we spoke with felt this was an area where more detailed training would be beneficial. The need for more detailed training was supported by a number of the health and social care professionals we spoke with. One told us, "The staff openly admit that they require training to help them manage people with serious mental health illness and challenging behaviours.… there is an increasing reliance on outside professionals to help them to manage their clients and seek guidance where they can procure it rather than the establishment provide the training for them".
We also noted that staff were not currently provided with training on breakaway techniques or restraint.

None of the registered nurses employed by the service were currently registered mental nurses (RMN's). One registered nurse was a registered learning disabilities nurse. We were concerned that this skill mix amongst the registered nurses was not reflective of the needs of people using the service. The provider told us they were trying to recruit further registered mental nurses.

Many of the people living at the service were living with conditions such as Huntington's disease, multiple sclerosis and acquired brain injuries. Whilst we were advised that the registered manager sometimes talked about specific conditions in the handovers we were not confident that staff were able to access a training programme that ensured they were able to develop a deeper understanding of these illness and disabilities and how they impacted on people. The activities staff had not undertaken specific training aimed at developing their skills with this role. A health care professional told us, "Whilst some staff have appeared more adept than others, there is evidence of a need for refreshing training with regards to medication, many [staff] are unaware of the side effects and regard medication as a means to manage behaviour".

We recommend that the provider review the training programme to ensure this is fully reflective of the needs of people using the service and equips them with the skills and knowledge needed to perform their role effectively.

Records did not always reflect that people's consent to care and treatment had been discussed or obtained. Some of the care plans viewed contained a 'Consent to Share Information' form, but many of these had not been signed by the person or by a legally appointed representative. This is an area for improvement. We looked at how staff were implementing the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were able to demonstrate an understanding of the MCA 2005 and talk about their responsibilities with regards to this.

A number of decision specific mental capacity assessments had been completed. For example, some people had mental capacity assessments regarding the management of their finances, the use of covert medicines and other complex decisions such as their choices about dietary intake. However, staff were not consistently undertaking mental capacity assessments when a person's behaviour or circumstances raised doubt about their capacity make a specific decision regarding their care and treatment. For example, one person's cognition plan described them as having learning difficulties which could affect their communication and limit their ability to make decisions. However their care plans did not include a mental capacity assessment or best interest's consultation. Assessing capacity is important to help prevent the risk of people making decisions they do not really understand.

Mental capacity assessments did not always include evidence of an appropriate best interest consultation. For example, three people were receiving their medicines covertly (without their knowledge). There was documentation to show that these people's capacity had been assessed and it had been discussed with the GP to determine that this was in these peoples' best interests. However for two of these people it was not clear whether the families had been consulted as part of the best interest's decision making. A recent audit had highlighted the need for improvements with regards to how and when mental capacity assessments were undertaken and documented. The registered manager told us action is being taken to make these improvements.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home. Some had been approved whilst others were awaiting assessment by the local authority.

Feedback about the food remained mixed. One person said, "The food is crap". Another person referred to the food as "Indifferent". A relative told us, "I don't know what the pudding was today". Some people were more positive. One person said, "The food is quite good" and another said, "The food is not too bad and we do get a choice…I can ask for something to eat between meals…There are plenty of drinks available". Each day there was a planned menu which included meals such as fish and chips, pasta, curries and pies. If people did not want the planned meal then they could choose from the daily alternative menu which included omelettes, salads, sandwiches or jacket potatoes. A survey had been completed to seek people's views about the food and meals they would like to see added to the menu. Changes had been made as a result of this, for example, the chef told us that one person had asked for hotpot and so this had been added onto the menu.

Information about people's dietary requirements was in the kitchen and the chef demonstrated a good understanding of these requirements and of people's individual likes and dislikes. Most people had a 'mealtime information' document in their rooms, this described how the person should be positioned for eating and drinking, the level of assistance they required, the type of diet they needed and potential risks associated with eating and drinking. Training was being provided by the local healthcare team to assist staff with developing their knowledge of people's special diets and of the national descriptors for modified diets.

We observed the lunchtime experience in a variety of locations throughout the service. Some people ate in the communal dining areas whilst others ate in their room or bungalow. The hot meals were brought to each floor in a heated trolley. Where people were known to be losing weight, their meal was served on a red tray to alert staff that the person needed extra encouragement to eat and drink. A variety of soft drinks were available and people were given the choice as to which of these they would like. Staff assisted people to eat and drink in a safe and person centred manner. They were patient and kind and spoke to people gently whilst helping them to eat and drink. Some people enjoyed some banter with the staff supervising the meal and they seemed to enjoy this. We observed a care worker using hand over hand techniques to support another person to eat as independently as possible and adapted cutlery and drinking cups were also available. Where people required a pureed meal, the different elements were all pureed separately so that people could still enjoy the individual flavours. Tea and coffee was served following the meal.

Some areas needed to improve. Staff and relatives told us that the 'soft' meals needed to be more varied. On the first day of our inspection, the water and squash jugs had not been refreshed since the previous day. Many of these were still full. We were concerned that this might mean people were not being offered regular drinks. Dinner tables were not laid with clothes and there were no serviettes or condiments available for people to use to season their meal. Staff completed food and fluid charts to help monitor how much people were eating and drinking. Staff told us these were not always completely accurately as some staff wrote down the name of the meal served and not how much of this had been eaten. We saw this happen. This limited the effectiveness of the charts as monitoring tools. We also noted there was a significant amount of waste following each lunchtime meal and so we were concerned that indicated people were not enjoying their food or that they were being given an inappropriate portion size.

People living at this service had complex health and social care needs and so a range of healthcare specialists were involved in their care. A local GP visited the service once a week to complete a 90 minute

review of people's health. Staff had worked with other health care professionals such as the community mental health team and consultant psychiatrists when people's mental health declined. People were supported to have eye tests and where they were experiencing difficulties with eating or swallowing their food, they had been referred to specialists such as speech and language therapists. A health care professional told us they had developed good relationships with the senior nurses and that advice regarding wound management was appropriately sought. A registered nurse we spoke with during the inspection displayed a good knowledge of one person's diabetic regime and they were also able to clearly articulate the management plan for one person with epilepsy.

Improvements could be made to ensure that aspects of the environment were more suited to people's needs. Many of the people using the service were wheelchair users, but many of the notice boards providing information were positioned too high. Some of the bungalows give little room for people who use individualised wheelchairs sufficient space to freely move around their environment, promoting their independence. Some people told us that repairs often took some time to complete. For example, one person told us their profiling bed had been stuck in a slightly upright position for some days and that their toilet seat was broken. Records showed that the provider had an ongoing plan for improvements to the environment which included replacing the flooring and updating the ensuite bathrooms. We were able to see that this was underway.

The main house was not secure. People needed only to press a button on the wall to open the front doors from the inside. It was positive that people were being supported to have free access to the community and to the grounds. However, we were concerned that some of the people living in the main house were subject to a DoLS. We were concerned they or other vulnerable people might leave the premises without staff being aware potentially placing them at risk of harm. The registered manager told us the risk of people absconding was low and that CCTV had recently been installed to assist in monitoring the entrance. They told us this would assist them in identifying when people left the building and what they were wearing. However, we recommend that the service review these arrangements to ensure they are safe and meet the needs of people using the service.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "Yes they are kind people". Another person said, "When I was ill very ill in bed there was someone to look after me…The regular staff are very caring…They do things at my pace". A relative told us, "This is where I wanted [the person] to come, the staff are brilliant, I can't fault them". Health and social care professionals were positive about the caring nature of staff and felt people were treated with dignity. One professional told us, "Staff try to ensure that dignity is maintained….I have not witnessed any disrespect and some of the staff appear to have developed good working relationships with people". Another said, "The staff are respectful and provide a dignified service…they appear to be caring towards my patients".

During our inspection, we saw many examples, of positive and warm interactions between people and staff. We saw staff smiling and joking with people and chatting with them about how their weekend had been and their forthcoming plans. At lunch staff supported people in a person centred manner. They explained to people what the meal was and asked them if they wanted to wear an apron to protect their clothes. Staff readily spoke with people whilst supporting them to eat and drink, asking how the food was, would they like a drink, or another pudding. A staff member gently asked a person if they could wipe their mouth. We observed a person lying in bed crying. A staff member was holding their hand and talking to the person in a very gentle, patient manner. We observed that the person became much calmer and was soothed by the sensitive nature of the staff member. On another occasion, a person was struggling to transfer from their wheelchair to an armchair which they usually managed independently. The care worker was supportive and encouraging and used touch to reassure the person who was eventually able to manage the transfer. The care worker said, "There you go, well done, would you like a blanket". We observed that the reception staff knew people well and interacted and engaged with them in a very positive manner throughout our inspection. There were a small number of occasions when we felt staff needed to be more mindful of people's needs and rights. For example, we saw one person being assisted outside by staff. The person was not wearing appropriate clothing for the weather. We also visited one person in their room. They were in bed being observed by one to one care. Their room was very cold. We spoke with the care worker about this. They closed the window. A social care professional told us staff had taken away a bank card from one person who had to capacity to manage their own finances. Whilst staff perhaps felt they were doing this for the right reasons, this was not respectful of the person's right to choose how they spent their money.

Staff were passionate about their role and spoke about the importance of developing a good relationship with the people they supported. One care worker said, "I want to make sure everybody is happy, settled, I want to make their lives better…I think, how would I like to feel…I never want anyone to feel alone". Another staff member said, "I love it here, love the residents". People told us that the permanent staff knew them well and that this had a positive impact on their care, for example, we observed one person being given a half a cup of coffee. When we asked why only half a cup they told us "that's how I like to have my drinks". Staff had a good understanding of how people communicated and used this effectively to talk with people about their care and support needs. For example, we saw one care worker asking a person who had no verbal communication if they needed anything. They encouraged the person to show them with their hands what it was they wanted. They also used sign language to ascertain whether the person wanted a cup of tea, a

cigarette or their chair tilting.

Staff encouraged people to make day to day decisions about their care, such as which meal choice they would like, or which movie they wanted to watch. At lunch time we heard staff asking people 'Do you mind if I help you' and 'Can I put an apron on you'. People's choices about the gender of their care workers had been recorded and people told us this was respected. Care plans were written in a manner that recognised the importance of caring for people in a dignified manner. For example, one person's personal care plan said, 'If [the person] spills food, gently offer to assist them to change their clothing and freshen up out of earshot of others'.

People's families were welcome to visit at any time. One relative told us, "They always make you feel welcome, nothing is too much trouble, everybody talks to you, asks you how you are". One of the assistant managers acted as a family liaison officer. Their role was to support family members to understand and adjust to their loved ones disabilities and to work in partnership with them to help ensure that the person got the best support possible.

The provider's core value was 'Dignity through Respect'. Our observations indicated that staff acted in a manner in keeping with this value. Staff continued to demonstrate a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person. Staff told us they were careful to ensure people's doors were closed when providing personal care and knocked on people's doors before entering their rooms. Where people chose to act in a manner that could compromise their dignity, staff acted to limit the impact of this where able.

Requires Improvement

Is the service responsive?

Our findings

Records relating to assessment and care planning were not consistently completed to a good standard. This increased the risk of people not receiving care that was responsive to their needs. Each person had a care plan which covered a range of areas including mental capacity, choking, eating and drinking and personal care. Some of the care plans were detailed and described in step by step instructions about how care should be delivered including moving and handling techniques. However, improvements were needed to ensure that each person's care plan was accurate and fully reflective of their needs. For example, the protocols for the use of as required medicines said one person could not communicate that they might be in pain. Their communication plan said, '[the person can express pain and discomfort'. Whilst they had a seizure plan, this did not record what type of seizure they experienced. Other care plans viewed contained similar inconsistencies or lacked key information. For example, one person's cognition plan said they were 'unable to make decisions…were unaware of risks and would put self in harm's way'. Their 'Use of bed rails' risk assessment said the person was 'Able to verbalise their needs and choices and preferred to have the bed rails up'. A healthcare professional told us care plans needed to be more detailed and more accurately reflect the complexity of people's health care needs such as their diabetic regimes. They told us they had raised concerns about the accuracy of information in care plans regarding people's dietary needs in February 2017. When they visited the service again in March 2017, they found similar concerns. For example, one person's care plan was not consistent with the guidance provided by a speech and language therapist.

Care plans needed to be more personalised. They contained lots of standard phrases. It appeared as if information was being copied and pasted from one person's care plan to another as we found several examples where people's care plans contained another person's name or referred to 'he' when the care plan was for a female. The quality and structure of care plans was variable and we were concerned this could make it difficult for agency staff to provide responsive care. Risk assessments were embedded within each care plan making them less accessible. In some cases the printed copies of care plans were not the most up to date version. This increased the risk of new, inexperienced staff or agency workers not having accurate information about people's needs. Some information was only available electronically such as information about people's weight or risk of malnutrition or of developing skin damage. A healthcare professional told us the structure of the care plans was an area that needed to improve. They said, "The care plans require a navigation tool to comprehend and few hours to read". The deputy manager told us there were plans to improve the information available to care staff in people's rooms. New care files were planned which included a copy of care plans, risk assessments and daily records. A trial of this was starting the week following our inspection.

Staff completed care booklets which were used to document the care provided. The daily booklets viewed were variable in terms of detail and quality. Some were good and included some information about the person's mood and wellbeing rather than just being task based. Others were less comprehensive. Where necessary, staff also completed booklets which recorded when a person had been repositioned and what they had eaten and drank throughout the day. Those viewed had generally been completed fully, but it was not always clear what action had been taken when for example, a person had had poor fluid intake.

One person was known to display behaviour which might challenge others and there were a number of incident forms relating to their care. Staff had been asked to complete ABC monitoring charts in response to incidents. The ABC approach is a way of recording the antecedents or triggers to a behaviour or incident and what happened immediately after the behaviour. It helps staff to analyse the behaviours and plan the measures which should be taken to reduce these. We were only able to find two ABC charts despite the person being involved in a large number of incidents. The content of the ABC charts was also poor. This combined with the lack of charts would have limited their use as a monitoring and planning tool.

At our last inspection we had concerns about the procedures in place for administering and recording the application of prescribed topical creams. We were told that topical medicines administration records (TMAR's) would be introduced. At this inspection we found that some people had TMARs but these were poorly completed or blank. For example, one person's TMAR had only been signed on four days out of 20. One chart was kept with the medicines records, but didn't contain clear guidance for care staff as to where and how to apply the preparation. A care worker told us, "You are taking a guess [when applying topical creams] using your own judgement". Two people who required topical creams didn't have these charts, but care staff had recorded in their daily notes that they had been applied. It was not possible to show from these records that these preparations had always been applied correctly.

The provider had not ensured that people had an accurate and complete record of the care and treatment provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We received mixed feedback about whether people always felt always felt involved in planning their own support. One person was positive about their involvement in care planning. They told us, "I have had my care plan read to me on more than one occasion and changes implemented". Others told us they had not seen their care plan and did not know what it said. Staff had completed care plan discussion' forms which were located in some people's records and were aimed at giving people and those close to them an opportunity to comment on their care. However, many of these just recorded 'no issues' and did not note who had been involved in the discussion. It was not generally evident how people were involved in their care plan evaluations. The registered manager told us it was the intention of the service to develop the key worker / named nurse system and work more closely with people's 'circle of support' to help ensure people felt more involved in making decisions about their care. This approach will need to be embedded and sustained so that improvements in this area can be achieved.

Care plans did include some information about the person, their likes and dislikes and preferred routines and the permanent staff had developed a good knowledge of people's individual needs which helped them to deliver care that was responsive to their needs. We spoke with three staff members about two people's needs. They knew the two people well and knew the interactions they had to follow to manage risks and possible behavioural issues each person might present with. A healthcare professional who had regular contact with the service praised the "Trusting therapeutic relationships" developed between people and their regular care workers. They felt this was a particular strength of the service.

Handovers were held twice daily, but staff reported that these varied in terms of their usefulness. One care worker said, "Some nurses come round and ask us how the person has been, others just look at the tick sheets". Another care worker told us handovers were "Better if permanent staff were on duty at night". Staff coming on at 2pm did not get a formal handover. We were told that the team leader on duty would update them. Staff told us this did not always happen effectively. We sat in on one handover. There was evidence that the permanent care staff knew people well and they were able to share some very individualised information about people's needs. For example, staff knew one person would only have a shower in the

afternoon and that another person liked a particular flavour of mousse. However, some of the information shared did not demonstrate that staff had a proactive approach to meeting people's needs despite the challenges this might present at times. For example, a registered nurse said, '[the person] has declined everything, so yeah'. There was no request for staff to revisit this lady and re-offer support.

We looked at the activities provision within the service. All staff had a role in spending time with people but a dedicated lead worker for activities had also just been appointed and provided activities on either four or five afternoons a week for six hours. They were enthusiastic about their role and committed to improving the activities provided within the service. They were spending time with people, learning about their lives before they came to live at the service and about their interests. They told us how some of the residents were very keen on football and so a trip had been arranged to a local pub for them to watch a game and have a meal. Another person had an interest in trains and so staff had obtained a train for another person to paint. Even though they were only able to do this for short periods of time, we were advised that the person did appear to enjoy this. The activities lead was hoping to repeat last year's success of people getting involved in growing vegetables and flowers. Parties were arranged for special events such as birthdays and Valentine's day. One relative told us staff had gone to great lengths to make their family members birthday party special including decorating their room. External entertainers visited approximately once a month and included an exercise class, a harpist, a mobile farm experience and a musical company. People also had the opportunity to take part in religious worship every other Sunday. Records showed that people who preferred to spend time in their rooms were also visited and offered the opportunity to get involved in games or puzzles, but if they did not wish to then their wishes were respected. Activities such as foot spas, nail painting, board games and movies were organised. The service had two minibuses and the lead worker told us they were planning a range of day trips in the summer and were speaking with people to get their views about where they would like to visit. People were also supported to go shopping, for example, as long as a driver was available.

Some people told us, however, that more could still be done to ensure they each had access to a meaningful and varied programme of activity and engagement that helped to improve their wellbeing. For example, one person told us, "Staff don't' have time to chat a lot". Another person when asked what the service could do better said, "Spend more time with you, I would love to have the opportunity to socialise more…I was delighted when they told me there was going to be a singing group starting, I went along for one evening, they never had another session". This person told us "It can be very noisy at times when residents kick off because they are bored". The service had a large activities hall. This was not a separately staffed building with a timetable of events but rather a place where people could go with their support workers to take part in group or individual activities based upon the person's wishes, abilities and preferences. The hall contained a swimming and hydrotherapy pool and a Jacuzzi which were available for leisure activities if appropriately qualified staff were on duty. This area was not well utilised by people. One person told us, "I like going swimming but have not been for some months". They told us staff had been meant to take them the week prior to our inspection, but this had not happened. They were not sure why. A healthcare professional told us that two of the people they worked with had expressed an interest in using the pool but this had not yet been facilitated. On the day we inspected, staff had used the hall to have lunch leaving their dirty plates behind. This would not have made the area welcoming to people.

A healthcare professional told us that their client with complex needs required a programme of interaction by staff who knew the person and their interests well. They told us their client was not getting this. Another healthcare professional told us, "Where I think they [the service] need to improve is in the holistic areas and organising activities for the more able bodied clients". We saw a lack of evidence that the one to one time was effectively used to support people with mental health needs to engage in activities that had a recovery focus. For example, one professional told us more needed to be done to support people with achieving

goals. Another professional also told us that the activities and therapeutic programme needed to improve. They said, "I have observed staff carrying out activities where possible….however, in Bonhomie there is a sense of apathy and loss of motivation. I have witnessed one to one with very little engagement with those in their charge".

We recommend that the provider review its activities provision to ensure that this provides sufficient opportunities social interaction and meaningful engagement.

The general manager told us they had recently worked with two people to develop recovery plans aimed at helping them overcome their mental health problems and work toward identified goals. This is an area which will need to be further embedded in practice and sustained in order to be an effective approach to support wellness and recovery.

At the time of the inspection, complaints policies and procedures were not displayed within the home and this limited their availability to people or their relatives. There was evidence, however, that where people or their family members had raised concerns about the care provided that the leadership team had tried to address the matter and there was evidence that a number of complaints had been investigated and a response made to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. There was scope for greater consultation with people about their views on the quality of the care and support provided and in matters relating to the running of the home. Records confirmed that 'Residents Meetings' took place, but the minutes of these did not clearly evidence how people's views and wishes were being acted upon. The provider had completed a satisfaction survey with people in February 2016 but the rate of return was very low with just three responses. A number of the people did not feel confident that their comments, concerns or views were always listened to and used to drive lasting improvements within the service. For example, one person said, "[the registered manager] he's alright, but nothing gets done on an organised basis, he's not a manager, but a crisis worker". Another person said, "There's not much point going to management, nothing changes". A third person explained "I go to resident's meetings and say what I mean. They may not like it…I like to hear what others are saying but nothing seems to change." This was echoed by a fourth person who told us, "I don't go to Residents meetings any more as nothing changes". Relatives expressed similar concerns. One relative said, "They say we will introduce this and introduce that, but you never see any improvement". Another said, "With a bit more organisation, it could be there". Staff told us they felt the registered manager did try and listen to them, but some felt that it often took too long for changes to happen as a result of their comments. A staff survey had taken place in February 2016 but there had been no responses at all. The registered manager told us that to encourage staff feedback the survey was being redesigned and a staff recognition scheme was being introduced.

Some of the provider's policies needed to be reviewed or updated. For example, the provider's induction policy dated back to 2006. It made no reference to the introduction of the Care Certificate. The quality assurance policy made reference to a previous regulatory body. None of the policies viewed included a review date. This is important as it helps to ensure that policies and procedures are updated in line with current legislation and best practice guidance.

Annual checks were made to ensure that the registered nurses were currently registered with the Nursing and Midwifery Council (NMC), however when we viewed these checks, three of these were out of date, two of them by four months. These checks are important as they provide reassurances that the registered nurses remain fit to practice. The registered manager has since confirmed that these checks have been updated, however the failure to monitor these could have placed people at risk. This was a failing in the provider's quality assurance processes.

The above evidence is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Good governance.

People, their relatives and some healthcare professionals told us that communication within the service was not always good. One person said, "I was told this morning that I have a hospital appointment this afternoon". A relative said, "Communication is not good, I wrote a letter to the manager, I have just wrote another, I have still not had a reply". Whilst kitchen staff were generally well informed about people's dietary needs, they were not always informed when for example, people were admitted to hospital. The chef told us

he had been preparing a meal for one person for three days before staff told him the person was in hospital. On the second day of our inspection, we spoke with staff supporting one person who was nutritionally compromised and required a modified diet. They told us the person loved pasta and tuna but that mashed potato kept being sent which she declined to eat. We observed this person being supported to eat on the third day of our inspection. They were again being fed a meal which included mashed potato. We heard them say, 'no mash'. We spoke with the chef about this. He was not aware of this person's dietary preferences, but said he would ensure this was addressed. The nursing and care staff based in the house told us they worked in an integrated manner, sharing concerns or information about people's healthcare needs however staff working in the satellite bungalows told us they often reported concerns about people or events but did not get any feedback about their concerns. They felt demoralised by this. A healthcare professional told us they were often frustrated that agreed treatment plans were not followed as a result of "Information not being cascaded effectively from the top down".

Health care professionals told us they felt the management team were at times struggling to deliver the quality of care they wanted to provide and which people had a right to expect. One healthcare professional told us, "Staff have left due to the pressures placed upon them and the trained nurses appear 'burnt out'. Another professional said, "I feel the manager is doing the best they can but may not be getting enough support to make the changes as necessary".

A more comprehensive range of quality assurance systems were in place. A range of internal audits were taking place. The senior management team had started to complete a monthly audit which assessed the service against the Key Lines of Enquiry (KLOEs) as used by the Care Quality Commission. The audits had identified where improvements had been made and suggested areas for further development, although we found no action plan to show how these matters were being taken forward. Staff completed quarterly health and safety checks to help identify any risks or concerns in relation to the environment. An infection control audit had also been completed in January 2017 and had reviewed issues such as the cleanliness of the bedrooms, kitchen and bathrooms. The provider had engaged consultants to support the registered manager in assessing the safety and quality of the service. They had recently completed detailed care audits. These had highlighted a number of areas where the care plans needed to improve and action was being taken to address these, but this remained a work in progress. Senior staff were undertaking observations of personal care and mealtime routines to ensure these were taking place in an effective and person centred manner. There was a service improvement plan in place. This is a plan that highlights what the service was doing well and the areas it could improve on and the timescales for achieving these.

The registered manager had been at the service for just over a year and from our discussions with them, they clearly knew people, the staff team and visiting professionals well. The registered manager told us he was proud of the staff team. He said, "They are caring and do a good job". He felt the service was more open and transparent that it was a year ago. We found that the registered manager was willing and committed to making improvements to the service, they told us that when things go wrong, it was important to learn from these and make improvements. We were able to see that some improvements had been made since our inspection. Staff were receiving more supervision and medicines were being more appropriately managed and disposed of safely. More robust systems had been put in place to review, investigate and learn from incidents and accidents and safeguarding concerns that happened within the service. However, many of these systems were still in their infancy or needed to be further developed in order to bring about lasting improvements and support the management functions of the home.

There remained a number of challenges for the provider and registered manager. The service supports people with a range of very complex physical and mental health needs which many other services would not be able or willing to care for. Staff require additional specific training to understand and support people with

complex conditions. There are very few 'quiet' days when staff can take time to attend to improving the accuracy and personalisation of people's care plans and records. The registered manager reported ongoing difficulties in sharing information and managing the transfer of people from and to hospital or to other healthcare services. Recruitment of staff remains problematic and this impacted upon the registered manager having a stable staff team which had limited the progress made with improvements.

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 had not done all that was reasonably practicable to assess and mitigate the risks to people's health and safety. The provider had not ensured that all aspects of the premises were safe to use for their intended purpose. Regulation 12 (1) (2) (a) (b) (d) Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that people had an accurate and complete record of the care and treatment provided. Regulation 17 (2) (c) Good governance. The provider did not have fully effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (b) Good governance. The provider did not have effective systems in place to actively seek and act on feedback from relevant persons. Regulation 17 (2) (e) Good governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs at all

time. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.